State of Indiana
Medicaid DUR Annual Report

For Federal Fiscal Year 2003

(October 1, 2002 to September 30, 2003)

Presented to:
Center for Medicare and Medicaid Services (CMS)

By: ACS State Healthcare, PBM Group

Under the direction of the
Indiana Office of Medicaid Policy and Planning
&
Indiana Drug Utilization Review Board

Date: 6/17/2004

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CMS SURVEY

DRUG UTILIZATION REVIEW (DUR) ANNUAL REPORT
FEDERAL FISCAL YEAR 2003

I. STATE CODE

IN

II. MEDICAID AGENCY STAFF PERSON RESPONSIBLE FOR DUR ANNUAL REPORT PREPARATION

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III. PROSPECTIVE DUR

1. During Federal Fiscal Year 2003 prospective DUR was conducted : (check those applicable)

   a) By individual pharmacies on-site.

   b) ___ On-line through approved electronic drug claims management system.

   c) __X__ Combination of (a) and (b).

2. a) States conducting prospective DUR on-site have included as **ATTACHMENT 1** (check one):

   _____ Results of a random sample of pharmacies within the State pertaining to their compliance with OBRA 1990 prospective DUR requirements.

   __X__ Results of State Board of Pharmacy monitoring of pharmacy compliance with OBRA 1990 prospective DUR requirements.

   _____ Results of monitoring of prospective DUR conducted by State Medicaid agency or other entities.

   (b) States conducting prospective DUR on-line have included as **ATTACHMENT 1**
   a report on State efforts to monitor pharmacy compliance with the oral counseling requirement.
   Yes __X__ No _____

3. States conducting prospective DUR on-site plans with regards to establishment of an ECM system. State:

_____ Has no plan to implement an ECM system with prospective DUR capability.

Plans to have an operational ECM system with prospective DUR in FFY 2003 or later.

STATES PERFORMING PROSPECTIVE DUR ON-SITE SKIP QUESTIONS 4-8

4. States conducting prospective DUR through an operational on-line POS system provide the following information:

a) Operational date **09/95** (MM/YY) on which on-line POS system began accepting drug claims for adjudication from providers.

b) Operational date **03/96** (MM/YY) on which on-line POS system began conducting prospective DUR screening.

c) Percentage of Medicaid prescriptions processed by ECM system (where applicable) in FFY 2003. **96.81 %** by ACS 03/23/2003-09/30/2003.

d) Identify ECM vendor.
Electronic Data Systems (EDS) 10/01/2002-03/22/2003
ACS State Health Care Solutions 03/23/2003-09/30/2003
(company, academic institution, other organization)

1) Was system developed in house? Yes **X** No ____
2) Is vendor Medicaid Fiscal agent? Yes **X** No ____

e) Identify prospective DUR (source of criteria).
First Data Bank with review and approval of DUR Board
(company, academic institution, other organization)

5. With regard to prospective DUR criteria from the vendor identified in 4 (d) above, the DUR Board: (Check one)

(a) _____ Approved in FFY 2003 all criteria submitted by the vendor.

(b) **X** Chose to approve selected criteria submitted by the vendor.

6 States checking 5 (b) have provided **DUR criteria** data requested on **enclosed Table 1.**
Yes **X** No _____

7. State prospective DUR screening includes screens run before obtaining DUR Board approval of criteria. Yes ____ No **X**

8. States conducting prospective DUR using an ECM system have included **ATTACHMENT 2**. Yes **X** No ____

IV. RETROSPECTIVE DUR

1. Identify your retrospective DUR vendor during FFY 2003.

   Affiliated Computer Services (ACS) State Healthcare Solutions
   (company, academic institution or other organization)

   a) Is the retrospective DUR vendor also the Medicaid fiscal agent?
   Yes _____ No **X**

   b) Is your current retrospective DUR vendor contract subject to re-bid in FFY 2003?
   Yes _____ No **X**

   If your vendor changed during FFY 2003, identify your new vendor.

   ACS State Healthcare Solutions – 01/01/2003 to 9/30/2003
   (company, academic institution or other organization)

   c) Is this retrospective DUR vendor also the Medicaid fiscal agent?
   Yes _____ No **X**

   d) Is this retrospective DUR vendor also the developer/supplier of your retrospective DUR criteria? Yes **X** No

2. If your answer to question 1(c) or 1(d) above is no, identify the developer/supplier of your retrospective DUR criteria.

   Not applicable
   (company, academic institution, or other organization)

3. Did DUR Board approve all retrospective DUR criteria supplied by the criteria source identified in questions 1(c) and 2 above? Yes _____ No **X**

4. States performing retrospective DUR have provided DUR Board approved criteria data requested on enclosed hardcopy **Table 2**. Yes **X** No _____

5. States conducting retrospective DUR have included **ATTACHMENT 3**.
   Yes **X** No _____

V. DUR BOARD ACTIVITY

1. States have included a brief description of DUR Board activities during FFY 2003 as **ATTACHMENT 4**. Yes **X** No _____

2. States have included a brief description of policies used to encourage the use of therapeutically equivalent generic drugs as **ATTACHMENT 5**.
   Yes **X** No _____

VI. PROGRAM EVALUATION/COST SAVINGS

1. Did your State conduct a DUR program evaluation/cost savings estimate in FFY 2003? Yes **X** No

2. Did you use Guidelines for Estimating the Impact of Medicaid DUR as the basis for developing your program evaluation/cost savings estimate?
   Yes **X** No

3. Who conducted your program evaluation/cost savings estimate?

   Affiliated Computer Services (ACS) State Healthcare Solutions
   (company, academic institution, or other organization)

4. States have provided as **ATTACHMENT 6** the program evaluations/cost savings estimates. Yes **X** No ___

Table 1:
ProDUR Criteria

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

TABLE 1.A PROSPECTIVE DUR CRITERIA
Approval Process

FOR EACH PROBLEM TYPE BELOW
LIST (DRUGS/ DRUG CATEGORY/ DISEAS E COMBINATIONS) FOR WHICH DUR BOARD CONDUCTED IN- DEPTH REVIEWS.
PLEASE INDICATE WITH AN ASTERISK (*) THOSE FOR WHICH CRITERIA WERE ADOPTED.

*Implementation Dates were all prior to FFY 2003

INAPPROPRIATE DOSE	THERAPEUTIC DUPLICATION	DRUG ALLERGY INTERACTION
1.	1. *See Table 1.A.2	1.
2.	2.	2.
3.	3.	3.

INAPPROPRIATE DURATION	DRUG/ DRUG INTERACTIONS	DRUG DISEASE CONTRAINDICATION
1. *Over utilization (Early Refill) All Drug Products	1. *Severity Level 1 (Requires PA)	1. *See Table 1.A.1
2. *Underutilization (Late Refill) Anti-Convulsants, Oral Hypoglycemics, ACE Inhibitors, Xanthines	2.	2.
3. *34-Day Supply for Non-Maintenance (Requires PA)	3.	3.

OTHER DRUG PREGNANCY *(specify)*	OTHER HIGH DOSE *(specify)*	OTHER DRUG-AGE/PEDIATRIC *(specify)*
1. *Severity Level X	1. *All Drug Products	1. *Severity Level 1
2. *Severity Level D	2.	2.
3. *Severity Level 1	3.	3.

TABLE 1.A ProDUR Criteria --continued--

TABLE 1.A.1 Drug-Disease Criteria

The DUR Board chose NDCs that infer a disease instead of using medical claims and ICD-9 diagnosis codes. Below are the criteria that were approved.

INFERRED DISEASE	INFERRING DRUG(S)	DISEASE DURATION	CONTRAIND DRUG(S)
Alcoholism	Disulfiram	Lifetime	Benzamphetamine Diethylpropion Fenfluramine MAO-Is Mazindol Phenmetrazine Phendimetrazine Phentermine Methotrexate Bexarotene
Alzheimer's	Tacrine	Lifetime	Aluminum
Arrhythmias	Procainamide	Lifetime	Dopamine Probucol Bepridil Itraconazole Ibutilide Dofetilide
Calcium Renal Calculi Prophylaxis	Cellulose sodium phosphate	Lifetime	Calcium phosphate Calcium carbonate
Chronic Angina Pectoris	Bepridil	Lifetime	Serotonin 5-HT1 Agonists Yohimibine Aldesleukin
Congestive Heart Failure	Amirnone Milrinone	Lifetime Lifetime	Cyclobenzaprine MAO-Is Pargyline Procarbazine Sodium phos laxatives Propranolol Iothalamate Albumin Hetastarch Corticotropin Gold salt compounds Doxorubicin Metformin Itraconazole Daunorubicin Iodixanol Sibutramine Cilostazol

TABLE 1.A ProDUR Criteria --continued--

TABLE 1.A.1 -- continued – Drug-Disease Criteria (continued)

Drug-Disease Criteria (continued)

INFERRED DISEASE	INFERRING DRUG(S)	DISEASE DURATION	CONTRAIND DRUG(S)
Cushing's Syndrome	Trilostane	Lifetime	Corticotropin
Diabetes Mellitus	Antidiabetic Drugs Acetohexamide Glipizide Glyburide Tolbutamide Tolazamide, etc Insulin	Lifetime	Lactulose
Diarrhea	Attapulgite Diphenoxylate/Atropine Kaolin/pectin/belladonna Opium/paregoric Loperamide	Finite	Magnesium Magaldrate Irinotecan Poliovirus vaccine
Epilepsy	Mephenytoin Doxapram Maprotiline Metoclopramide Piperazine	Lifetime	Bupropion
Hyperkalemia	Sodium polystyrene Sulfonate	Lifetime	Amiloride Potassium/sodium citrate Spironolactone Methazolamide Triamterene Acetazolamide Mesoridazine Dichlorphenamide
Hypertension	Alseroxylon Benazapril-Amlopdipine B-Blockers plus: Bendroflumethiazide Chlorthalidone HCTZ Losarten Moexipril	Lifetime	Benzamphetamine Diethylpropion Fenfluramine Mazindol Methylergonovine Phentermine Sodium phos laxatives Dozapram Phenmetrazine Phendimetrazine Dextrothyroxine Anistlepase Corticotropin Gold salt compounds

TABLE 1.A ProDUR Criteria --continued--

TABLE 1.A.1 Drug-Disease Criteria (continued)

INFERRED DISEASE	INFERRING DRUG(S)	DISEASE DURATION	CONTRAIND DRUG(S)
Hyperthyroidism	Methimazole Prophylthiouracil	Lifetime	Benzamphetamine Cyclobenzaprine Diethylproprion Phendimetrazine Phenmetrazine Phentermine Ritodrine Midodrine Arbutamine
Mental Depression	Amoxapine	Lifetime Diazepam	Flurazepam Bupropion MAO-I Clomiphene Nortriptyline Metoclopramide Venlafaxine Interferon-Alpha 2B
Myasthenia gravis	Ambenonium	Lifetime	Orphenadrine Streptomycin Gentamicin Tobramycin Amikacin Netilmicin Doxacurium
Parkinsonism	Carbidopa/Levodopa Levodopa Pergolide Selegiline	Lifetime	Haloperidol Streptomycin Gentamicin Tobramycin Amikacin Netilmicin Gramicidin
Peripheral Vascular Disease	Pentoxiphylline	Lifetime	Methylergonovine Dihydroergotamine Serotonin 5-HT1 Agonists
Pheochromocytoma	Metyrosine	Lifetime	MAO-Is Metoclopramide Pargyline Droperidol Dopamine Metoclopramide Midodrine

TABLE 1.A ProDUR Criteria --continued--

TABLE 1.A.1 Drug-Disease Criteria (continued)

INFERRED DISEASE	INFERRING DRUG(S)	DISEASE DURATION	CONTRAIND DRUG(S)
Prostatic Cancer	Busereline Estramustine Flutamide	Lifetime	Fluoxymesterone Methyltestosterone Nadrolone Oxandrolone Oxymetholone Prasterone Testosterone HCG Hormone
Psychotic disorders	Acetophenazine Molindone Promazine Thiothixene Trifluoperazine	Lifetime	Mazindol Flurazepam
Tuberculosis	Capreomycine Pyrazinamide	Lifetime	Infliximab
Urinary tract infection	Cinoxacine Methenamine Naladixic acid Nitrofurantoin	Finite	BCG live Potassium/Sodium citrate
Ventricular arrhythmias	Encainide Esmolol Flecainide Mexiletine Moralizing Sotalol Oceanside	Lifetime	Bepridil Dopamine Probucol Itraconazole Ibutilide Dofetilide
Wilson's Disease	Turpentine	Lifetime	Copper supplements

TABLE 1.A ProDUR Criteria --continued--

TABLE 1.A.2 Therapeutic Duplication Alert Criteria

Class Code	Description
	Cardiovascular Agents
A1C	Inotropic Drugs
A2A	Antiarrythmics
A4A	Hypotensives, Vasodilators
A4B	Hypotensives, Sympatholytic
A4C	Hypotensives, Ganglionic Blockers
A4E	Hypotensives, Veratrum Alkalo ids
A4Y	Hypotensives, Miscellaneous
A7A	Vasoconstrictors, Arteriolar
A7B	Vasodilators, Coronary
A7C	Vasodilators, Peripheral
A7D	Vasodilators, Peripheral (continued)
Z4D	Prostacyclines
	ACE Inhibitors and Antagonists
A4D	Hypotensives, ACE Inhibitors
A4F	Hypotensives, Angiotensin Receptor Antagonists
A4K	ACE Inhibitor/Calcium Channel Blocker Combination
	Calcium Channel Blocking Agents
A9A	Calcium Channel Blockers
	H2-Antagonists
D4E	Anti-Ulcer Preparations
D4F	Anti-Ulcer H. Pylori Agents
Z2D	Histamine H2-Receptor Inhibitors
	Phenothiazines
H2G	Anti-Psychotics, Phenothiazines
H2I	Anti-Psychotics, Phenothiazines (continued)
	Antidepressants
H2J	Antidepressants
H2K	Antidepressants Combinations
H2N	Antidepressants (continued)
H2S	Serotonin Specific Reuptake Inhibitors (SSRIs)
H2U	Tricyclic Antidepressants & Rel. Non-Sel. Reuptake Inhibitors
H2W	Tricyclic Antidepressants/Phenothiazine Comb
H2X	Tricyclic Antidepressants/Benzodiazepine Comb
H2Y	Tricyclic Antidepressants/Non-Phenothiazine comb.
H7A	Tricyclic ADP/Phenothiazine/Benzodiazepines
H7B	Alpha-2 Receptor Antagonist Antidepressants
H7C	Serotonin-Norepinephrine Reuptake Inhibitors
H7D	Norepinephrine & Dopamine Reuptake Inhibitors
H7E	Serotonin 2-Antagonist/Reuptake Inhibitors
H7F	Selective Norepinephrine Reuptake Inhibitors
H7G	Serotonin and Dopamine Reuptake Inhibitors
H7H	Serotonin Specific Reuptake Inhibitor/Ergot Comb

TABLE 1.A ProDUR Criteria --continued--

TABLE 1.A.2 -- (continued) -- Therapeutic Duplication Alert Criteria (continued)

Class Code	Description
	Antidepressants - continued –
H7I	Antidepressant/Barb/Belladonna Alkaloid Comb
H7J	MAOIs-Non Selective and Irreversible
H7K	MAOIs-A Selective and Reversible (RIMA)
H7L	MAOIs N-S & Irreversible/Phenothiazine Comb
H7M	Antidepressant/Carbamate Anxiolytic Combination
	Narcotic Analgesics
H3A	Analgesics, Narcotics
H3B	Analgesics, Narcotics (continued)
H3H	Analgesics Narcotic, Anesthetic Adjunct Agents
	Non-Narcotic Analgesics
H3C	Analgesics, Non-Narcotics
H3E	Analgesics/Antipyretics, Non-Salicylates
H3F	Antimigraine Preparations
H3G	Analgesics, Miscellaneous
	Alpha and Beta Blockers
J7A	Alpha/Beta-Adrenergic Blocking Agents
J7B	Alpha-Adrenergic Blocking Agents
J7C	Beta-Adrenergic Blocking Agents
J7D	Beta-Adrenergic Blocking Agents (continued)
J7E	Alpha-Adrenergic Blocking Agent/Thiazide Comb
	Anti-Lipidemics
M4E	Lipotropics
M4F	Lipotropics (continued)
	Diuretics
R1B	Osmotic Diuretics
R1C	Inorganic Slat Diuretics
R1D	Mercurial Diuretics
R1E	Carbonic Anhydrase Inhibitors
R1F	Thiazide and Related Diuretics
R1G	Thiazide and Related Diuretics (continued)
R1H	Potassium Sparing Diuretics
R1J	Aminouracil Diuretics
R1K	Diuretics, Miscellaneous
R1L	Potassium Sparing Diuretics in Combination
R1M	Loop Diuretics
	NSAIDS and Salicylates
S2B	NSAIDS, Cyclooxygenase Inhibitor Type
S2D	NSAIDS, Cyclooxygenase Inhibitor Type (continued)
S2E	NSAIDS, Cyclooxygenase Inhibitor Type (continued)
S2H	Anti-Inflammatory/Antiarthritic Agents, Misc.
S2I	Anti-Inflammatory, Pyrididine Synthesis Inhibitors
S2L	NSAIDS, Cyclooxygenase 2 Inhibitor Type
S7C	Skeletal Muscle Relaxant & Salicylate Combination
H3D	Analgesics/Antipyretics, Salicylates

TABLE 1.A ProDUR Criteria --continued--

TABLE 1.A.2 --(continued)--

Therapeutic Duplication Alert Criteria (continued)

Class Code	Description
	Antimicrobial Products
W1A	Penicillins
W1B	Cephalosporins
W1C	Tetracyclines
W1D	Macrolides
W1E	Chloramphenicol and Derivatives
W1F	Aminoglycosides
W1G	Antitubercular Antibiotics
W1H	Aminocyclitols
W1I	Penicillins (continued)
W1J	Vancomycin and Derivatives
W1K	Lincosamides
W1L	Antibiotics, Miscellaneous, Other
W1M	Streptogramins
W1N	Polymyxin and Derivatives
W1O	Oxazolidinones
W1P	Betalactams
W1Q	Quinolones
W1R	Beta-Lactamase Inhibitors
W1S	Carbapenams (Thienamycins)
W1T	Cephalosporins (continued)
W1U	Quinolones (continued)
W1V	Steroidal Antibiotics
W1W	Cephalosporins – 1st Generation
W1X	Cephalosporins – 2nd Generation
W1Y	Cephalosporins – 3rd Generation
W2A	Absorbable Sulfonamides
W2B	Nonabsorbable Sulfonamides
W2C	Absorbable Sulfonamides (continued)
W2E	Nitrofuran Derivatives
W2Y	Anti-Infectives, Misc. (Antibacterials)

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TABLE 1.B PRIOR AUTHORIZATION (PA) CRITERIA

DD – Drug-Drug Interaction PA Criteria

The DUR Board approved to move to hard edits that require PA for Severity Level 1 interactions beginning 1/15/2003.

ER - Early Refill Alert PA Criteria

Implemented 7/1/2002, Early Refill editing is in place and all edits are hard edits ***except*** for those drugs or classes in the table below. Hard edits require a PA from HCE prior to claims payment. Exceptions to this (online override and Ignore / Inactive) are in the table below:

Class Description	Alert Status (A-POS Override; I-Inactive)
Q6I Eye Antibiotic-Corticoid Combinations	A
Q6R Eye Antihistamines	A
Q6P Eye Anti-inflammatory Agents	A
Q6Y Eye Preparations, Miscellaneous (OTC)	A
Q6S Eye Sulfonamides	A
M0F Factor IX Preparations	A
Q6G Miotics/Other Intraoc. Pressure Reducers	A
Q6W Ophthalmic Antibiotics	A
Q6U Ophthalmic Mast Cell Stabilizers	A
Q6A Ophthalmic Preparations, Miscellaneous	A
WG8 Antiseptics, General	I
X5B/X5E Bandages and Related Supplies	I
Y5A Braces and Related Devices	I
W1I Chemotherapy Rescue/Antidote Agents	I
Y9A Diabetic Supplies	I
C5F/C5T Dietary Supplement, Miscellaneous	I
Y3A Durable Medical Equipment, Misc. (Group 1)	I
Y3C Durable Medical Equipment, Misc. (Group 2)	I
Y0A Durable Medical Equipment, Miscellaneous	I
X4B Incontinence Supplies	I
C5C Infant Formulas	I
W8F Irrigants	I
X5A, X5C, X6A, X8P, X8V Medical Supplies	I
X2A Needles/Needleless Devices	I
C5U Nutritional Therapy, Med Cond Special Formulation	I
X3A Ostomy Supplies	I
Y7A Respiratory Aids, Devices, Equipment	I
X2B Syringes and Accessories	I

TABLE 1.B PA Criteria --continued--

TD – Therapeutic Duplication PA Criteria
(Implemented 7/22/2003)

Angiotensin Converting Enzyme Inhibitors (ACEIS)
Angiotensin Receptor Blockers (ARBS)
Calcium Channel Blocking Agents
Anti-Hyperlipidemics
Osmotic Diuretics
Inorganic Salt Diuretics
Mercurial Diuretics
Carbonic Anhydrase Inhibitors
Thiazide and Related Diuretics
Potassium - Sparing Diuretics
Aminouracil Diuretics
Potassium - Sparing Diuretics in Combination
Loop Diuretics
Penicillins
Tetracyclines
Macrolides
Chloamphenicol and Derivatives
Aminoglycosides
Antitubercular Antibiotics
Streptogramins
Aminocyclitols
Vancomycin and Derivatives
Lincosamides
Polymyxin and Derivatives
Oxazolidinediones
Betalactams
Quinolones
Beta-Lactamase Inhibitors
Carbapenems (Thienamycins)
Cephalosporins – 1st Generation
Cephalosporins – 2nd Generation
Cephalosporins – 3rd Generation
Cephalosporins – 4th Generation
Absorbable Sulfonamides
Non-Absorbable Sulfonamides

TABLE 1.B PA Criteria --continued--

HD – High Dose PA Criteria
(Implemented 3/28/2003)

Exceptions (covered by specific PDL edits): Hydrocodone/APAP
Oxycodone/APAP
Oxycodone

Exemptions from Hard Edits or PA's (Soft Overridable Edits at Point of Sale by Pharmacists):

Class Code	Descriptions
J5D	Beta-Adrenergic Agents
Q8B	Ear Preparations, Misc Anti-infectives
Q8W	Ear Preparations, Antibiotics
Q8H	Ear Preparations, Local Anesthetics
Q6I	Eye Antibiotic-Corticoid Combinations
Q6R	Eye Antihistamines
Q6P	Eye Anti-inflammatory Agents
Q6V	Eye Antivirals
Q6H	Eye Local Anesthetics
Q6S	Eye Sulfonamides
Q6C	Eye Vasoconstrictors (Rx only)
Q6G	Miotics/Other Intraoc. Pressure Reducers
H2A	Central Nervous System Stimulants
J1B	Cholinesterase Inhibitors
32480, 32481	Guanfacine HCl
01390, 01391, 01392	Clonidine HCl
H2H, H7L, H7K, H7J	Monoamine Oxidase (MAO) Inhibitors
H2E, H2Q	Selective-Hypnotics, Non-Barbiturate
H2S, H7H	Serotonin Specific Reuptake Inhibitor
H7E	Serotonin-2 Antagonist/Reuptake Inhibitors
H7C	Serotonin-Norepinephrine Reuptake-Inhibitor
H2X	Tricyclic Antidepressant/Benzodiazepine Combinations
H2W	Tricyclic Antidepressant/Phenothiazine Combinations
H2U	Tricyclic Antidepressant & Rel. Non-Sel. Reuptake Inhibit
H2L, H2O	Anti-Psychotics, Non-Phenothiazines
H2G, H2I	Anti-Psychotics, Phenothiazines
H4B, H4C	Anticonvulsants
H7P	Barbiturates
A9A	Calcium Channel Blocking Agents
Q6W	Ophthalmic Antibiotics
Q6U	Ophthalmic Mast Cell Stabilizers
Q6A	Ophthalmic Preparations, Miscellaneous
H2F, H2P	Anti-Anxiety Drugs
H2M	Anti-Mania Drugs
H2V	Anti-Narcolepsy/Anti-Hyperkinesis Agents

TABLE 1.B PA Criteria --continued--

MX – Inappropriate Duration PA Criteria

34-Day Supply Limit for Non-Maintenance Medications PA Criteria
(Implemented 7/1/2002)

All non-maintenance drug claims associated with the PDL requiring quantities greater than a 34-day supply will deny and require PA at the pharmacy POS. As with BMN, two distinct PAs will be required for claim approval, one for the PDL and one for the 34-day supply limitation. PA will not be granted unless an extenuating circumstance exists to substantiate the need to dispense greater than a 34-day supply of the product.

All non-maintenance drug claims not associated with the PDL requiring quantities greater than a 34-day supply denies at the pharmacy POS and PA is required. PA will not be granted unless an extenuating circumstance exists to substantiate the need to dispense greater than 34-days supply of the product.

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TABLE 1.C

INDIANA RATIONAL DRUG PROGRAM (IRDP) CRITERIA

The IRDP criteria were phased-out as the PDL program was phased-in over the Federal Fiscal Year 2003 (see Attachment 2.2 for more detail).

Stadol Nasal Spray:
- 1 vial limit per claim
- 2 vial limit per month
- Exclusions: 590 Program recipients

Tramadol Products:
- Ultram and Ultracet
- Exclusions: 590 Program recipients; Patients 70 yrs and older with 300mg/day or less of Tramadol

Brand Name NSAIDS, Brand Name Salicylates, COX-II Inh:
- Innovator NSAIDS and Salicylates, COX-II Inh
- Exclusions: 590 Program recipients and patients 70 yrs and older.

Peptic Ulcer Disease Drugs:
- PA for PPI therapy of greater than 90 days over past 12 months
- PA for H2 Antagonist therapy (therapeutic dosing) of greater than 90 days over past 6 months.
- PA for all Misoprostol containing products
- PA for Carafate greater than 2 grams per day for therapy greater than 30 days when taken concurrently with PPI of therapeutic dose of H2-Antagonist.
- Exclusions: 590 Program recipients

Growth Hormone:
- PA for all growth hormones
- Exclusions: 590 Program recipients

Tretinoin:
- PA for Tretinoin topical products
- Exclusions: 590 Program recipients and patients 20 years of age or less

Azithromycin:
- PA for Azithromycin products (tabs/caps/liquids) with days supply greater than 5 days.
- 5 days supply limitation per 10-day period.
- Exclusion: 590 Program recipients

Lactulose:
- All Lactulose Products
- Exclusion: 590 Program recipients

TABLE 1.C --(continued)– IRDP CRITERIA –continued–

Synagis and Respigam

- All products – PA approved only between 10/15 – 4/30 annually for maximum of 6 doses.
- Exclusion: 590 Program recipients

Oxycontin:

- PA for Oxycontin claim greater than 4 tablets per day.
- 120 tablet limitation for all strengths within previous 25-day period.
- Exclusion: 590 Program recipients

Oxycodone Immediate Release Products:

- PA for Oxycodone claims greater than 60mg per day, all dosage forms.
- 360 unit limitation for all dosage forms within previous 25-day period.
- Exclusion: 590 Program recipients

Fentanyl Topical Patch:

- Greater than 10 patches (all strengths) within previous 25-day period.
- Exclusion: 590 Program recipients

Acetaminophen with Hydrocodone/Oxycodone:

- PA for claims greater than 4 gms acetaminophen per day (all dosage forms)
- 270 unit limitation for all dosage forms within previous 25-day period.
- Exclusion: 590 Program recipients

Brand Medically Necessary:

- PA for all innovator, multiple-sourced drugs, and GPI 2 or 3 with State or Federal MAC rate
- Exclusion: 590 Program recipients; Claims for Coumadin, Provera, Synthroid; Tegretol; Lanoxin; Premarin; Dilantin, and claims with 06 override and days supply of 4 or less.

Table 2:
RetroDUR Criteria

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TABLE 2. RetroDUR Criteria

RetroDUR CRITERIA (Check All Relevant Boxes)	INDIANA MEDICAID MONTH	PROGRAM TYPE	PROBLEM TYPE PDL ED	OU	UU	DO	TD
ACEIs	OCTOBER 2002	IBM	X				
ACEIs	OCTOBER 2002	TAI	X				
ACEIs/CCBs	FEBRUARY 2003	TAI	X				
ACEIs/DIURETIC	FEBRUARY 2003	TAI	X				
ALBUTEROL INHALER	JANUARY 2003	RetroDUR		X			
ALL PDL DRUGS	SEPT 2003	IBM		X			
ALL PDL DRUGS	SEPT 2003	IBM	X				
ALL PDL DRUGS	SEPT 2003	TAI		X			
ALL PDL DRUGS	SEPT 2003	TAI	X				
ALPHA ADRENERIC BLOCKERS	DECEMBER 2002	TAI	X				
ALPHA/BETA BLOCKERS	DECEMBER 2002	TAI	X				
ALPHAGAN P	JUNE 2003	TAI	X				
ANTI ULCER/H PYLORI AGENTS	JUNE 2003	TAI	X				
ANTIDIABETICS	APRIL 2003	TAI	X				
ANTIDIABETIC COMBOS	APRIL 2003	TAI	X				
ANTIEMETIC/ANTIVERTIGO	MARCH 2003	TAI	X				
ANTIFUNGALS	MARCH 2003	TAI	X				
ANTIPSORIATICS	MAY 2003	TAI	X				
ANTIVIRAL ANTIHERPETIC	JUNE 2003	TAI	X				
ANTIVIRAL INFLUENZA	JUNE 2003	TAI	X				
ARBs	DECEMBER 2002	IBM	X				
ARBs	MARCH 2003	TAI	X				
ARBs	AUGUST 2003	TAI		X			
ARBs/DIURETICS	FEBRUARY 2003	TAI	X				
BETA BLOCKERS	DECEMBER 2002	TAI	X				
BILE ACID SEQUESTRANTS	APRIL 2003	TAI	X				
BLOOD THINNERS	MARCH 2003	TAI	X				
BPH	FEBRUARY 2003	TAI	X				
BRAND NAME NARCOTICS	APRIL 2003	TAI	X				
CCBs	DECEMBER 2002	TAI	X				
CEPHALOSPORINS	MARCH 2003	TAI	X				
CIPRO HC	JUNE 2003	TAI	X				
CIPRO XL	AUGUST 2003	TAI		X			
CSI	FEBRUARY 2003	TAI	X				
CSI	JANUARY 2003	RetroDUR			X		
DEPAKOTE EC	AUGUST 2003	TAI				X	
EYE ANTIHISTAMINES	MAY 2003	TAI	X				
FIBRIC ACIDS	APRIL 2003	TAI	X				
FLUOROQUINOLONES	MARCH 2003	TAI	X				
FORTEO	MAY 2003	TAI	X				
H2 BLOCKERS	APRIL 2003	RetroDUR			X		
HEMATINICS	MAY 2003	TAI	X				
LA/SA BETA AGONISTS	FEBRUARY 2003	TAI	X				
LEUKOCYTES STIMULANTS	MAY 2003	TAI	X				
LEUKOTRIENE INHIBITORS	JANUARY 2003	RetroDUR			X		
LEUKOTRIENE INHIBITORS	FEBRUARY 2003	TAI	X				
LIPOTROPICS	FEBRUARY 2003	TAI	X				

TABLE 2. RetroDUR Criteria – continued –

RetroDUR CRITERIA	MONTH	PROGRAM TYPE	PDL ED	OU	UU	DO	TD
LIPOTROPICS	SEPT 2003	RetroDUR				X	
LOOP DIURETICS	DECEMBER 2002	TAI	X				
MACROLIDES	MARCH 2003	TAI	X				
MIOTICS	MAY 2003	TAI	X				
NASAL CSI	FEBRUARY 2003	TAI	X				
NS ANTIHISTAMINES	OCTOBER 2002	TAI	X				
OPHTH ANTIBIOTICS	MAY 2003	TAI	X				
OPHTH. MAST STABALIZERS	MAY 2003	TAI	X				
ORAL ANTIFUNGALS	JUNE 2003	TAI	X				
OTIC ANTIBIOTICS	MAY 2003	TAI	X				
PLATELET INHIBITORS	DECEMBER 2002	TAI	X				
PPIs	SEPT 2003	TAI		X			
PPIs	SEPT 2003	TAI	X				
PPIs	OCTOBER 2002	TAI	X				
PPIs	APRIL 2003	RetroDUR		X			
SEREVENT	SEPTEMBER	TAI		X			
SERMS	JANUARY 2003	IBM	X				
SERMS	FEBRUARY 2003	IBM	X				
SERMS	MARCH 2003	TAI	X				
SHORT ACTING CCB	AUGUST 2003	TAI		X			
SMOKING DETERRENTS	MAY 2003	TAI	X				
SMRs	APRIL 2003	TAI	X				
SMRs	AUGUST 2003	TAI					X
SMRs	SEPT 2003	TAI					X
SSRIs	JULY 2003	IBM				X	
SSRIs	SEPT 2003	IBM					X
SSRIs	JULY 2003	TAI				X	
SSRIs	AUGUST 2003	TAI				X	
SSRIs	SEPT 2003	TAI				X	
THIAZOLIDINEDIONES	NOVEMBER 2002	IBM	X				
THIAZOLIDINEDIONES	FEBRUARY 2003	TAI	X				
THIAZOLIDINEDIONES	SEPT 2003	TAI	X				
TOPICAL ANTIFUNGALS	JUNE 2003	TAI	X				
TOPICAL ESTROGENS	JUNE 2003	TAI	X				
TRIPTANS	FEBRUARY 2003	TAI	X				
ULTRACET	MAY 2003	TAI	X				
URINARY TRACT ANTISPAS.	APRIL 2003	TAI	X				
VAGINAL ANTIMICROBIALS	JUNE 2003	TAI	X				
VITAMIN A DERIVATIVES	MAY 2003	TAI	X				
XANTHINES	JANUARY 2003	RetroDUR			X		

PROBLEM TYPE KEY	
OU =	Over Utilization
UU =	Under Utilization
TD =	Therapeutic Duplication
PDL ED =	Prescriber Education on PDL Alternatives

Attachment 1:
Pharmacy Survey Information

ATTACHMENT 1. PHARMACY SURVEY INFORMATION

Monitoring Pharmacy Compliance With OBRA '90 Prospective DUR Requirements

Prospective DUR (ProDUR)

Indiana Medicaid does not require the electronic claims management point-of-sale (POS)/ProDUR system by Indiana Medicaid Pharmacy providers, but those that do use the system have the benefit of the ProDUR information at the POS, but must take appropriate action before the claim will pay.

Some ProDUR edits require review by the pharmacy providers and are payable once the pharmacist reviews and overrides the ProDUR edit. Some ProDUR edits result a stop claim will not pay without prior authorization. At that time, pharmacy providers assess whether the drug is necessary, and may call the prescriber to verify if a prior authorization is necessary. ProDUR edits were performed POS during FFY 2003 for 96.8% Indiana Medicaid claims. The remaining 3.2% percent were paper claims.

Patient counseling portion of ProDUR

The Indiana Board of Pharmacy, in coordination with Indiana Medicaid, promulgated patient counseling regulations *(copy enclosed on next page)* that became effective January 1, 1993. These regulations ensure that pharmacist offer ProDUR counseling.

Indiana Board of Pharmacy is the controlling authority over the patient counseling regulations portion of OBRA '90. The Board of Pharmacy inspects pharmacies and measures conformance with patient counseling requirements. See copy of inspection form (see attachment on page 29). The Indiana Board of Pharmacy has requested that the Consumer Protection Division of the Indiana Office of the Attorney General forward all consumer complaints regarding patient counseling activities directly to the Board of Pharmacy. Joshua M. Bolin, Director, Indiana Board of Pharmacy reviewed all relevant records and determined that no complaints against pharmacists or pharmacies had been filed due to a lack of patient counseling during FFY2003.

Additionally, according to the ACS/Indiana Medicaid program pharmacy educator for FFY 2003, Mr. Harold Ross R.Ph., all pharmacies, with a few exceptions, are following the OBRA'90 requirements for oral counseling. Mr. Harold Ross has lectured to pharmacists and continually works with all pharmacies in the state to educate pharmacists on proper documentation methods for oral counseling.

Myers and Stauffer, LLC is contracted to conduct monthly claims audit/reviews. The contractor is required to review prescription records for appropriate and accurate documentation of: physician license numbers and signatures on prescriptions, collection of co-payments, brand dispensing where equivalent generic available, DAW 6 when generic dispensed, multiple dispensing fees, use of out-of-state provider ID numbers for in-state prescribers, returns and credits (*copy of Bulletin BT200330 is attached after inspection form).*

ATTACHMENT 1 –continued–

Indiana Administrative Code RE: Counseling

TITLE 856 INDIANA BOARD OF PHARMACY

Last Updated February 1, 2004

- ARTICLE 1. PHARMACIES AND PHARMACISTS

Rule 33. Counseling

Title 856 IAC 1-33-1 "Counseling" defined

Authority: IC 25-26-13-4
Affected: IC 25-26-13-4

Sec. 1. As used in this rule, "counseling" means effective communication, by a pharmacist, of information in order to improve therapeutic outcomes by maximizing the proper use of prescription medications and devices. *(Indiana Board of Pharmacy; 856 IAC 1-33-1; filed Dec 1, 1992, 5:00 p.m.: 16 IR 1176; readopted filed Nov 13, 2001, 3:55 p.m.: 25 IR 1330)*

856 IAC 1-33-2 Patient counseling requirements

Authority: IC 25-26-13-4
Affected: IC 25-26-13-16

Sec. 2. (a) Upon the receipt of a prescription or upon the subsequent refilling of a prescription, and following a review of the patient's prescription medication profile, the pharmacist shall be responsible for the initiation of an offer to discuss matters (counsel) which, in the pharmacist's professional judgment, are significant to optimizing drug therapy. Depending upon the situation, these matters may include, but are not necessarily limited to, the following:

(1) The name and description of the medicine.
(2) The route, dosage form, dosage, route of administration, and duration of drug therapy.
(3) Special directions and precautions.
(4) Common adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance and the action required if they occur.
(5) Techniques for self-monitoring drug therapy.
(6) Proper storage.
(7) Prescription refill information.
(8) Action to be taken in the event of a missed dose.

(b) Counseling shall be in person, whenever practicable, or through access to a telephone service which is toll free for long distance calls, and be held with the patient, the patient's caregiver, or the patient's representative.

(c) Alternative forms of patient information may be used to supplement verbal counseling when appropriate. Examples include, written information leaflets, pictogram labels, and video programs. Nothing in this subsection shall be construed to mean that supplements may be a substitute for verbal counseling when verbal counseling is practicable.

(d) Nothing in this rule shall be construed as requiring a pharmacist to provide counseling when a patient refuses the offer to counsel. *(Indiana Board of Pharmacy; 856 IAC 1-33-2; filed Dec 1, 1992, 5:00 p.m.: 16 IR 1176; readopted filed Nov 13, 2001, 3:55 p.m.: 25 IR 1330)*

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAM

INDIANA BOARD OF PHARMACY
INSPECTION REPORT
State Form 35890 (RA4/3-.95)

Name of pharmacy

Address (*number and street.* city, *state. ZIP* code)

Today's date and time	County	Telephone number	DEA number

CSR number	I.D. number	Type	Total weekly hours	Gen. appearance	Open for bus.

NAMES OF PHARMACISTS EMPLOYED	LICENSE NO.	PRESENT	ABSENT	WEEKLY HOURS	LICENSE CURRENT
MANAGER					
OTHERS					

	YES	NO
1. Are all certificates property displayed, current and correct?		
2. 1s the pharmacy equipped as required by law?		
3. Are Rx files properly kept?		
Including name and address of patient filed numerically and chronologically?		
Retained over a period of 2 years?		
Indicate type of filing system used:		
4. Are refills of Rx properly recorded?		
Where?		
5. Are Rxs being refilled beyond date of validity?		
6. Are refills being properly documented?		
7. If Sch. II Emer. Rx filled, are proper records kept?		
8. How do you handle return medications?		
9. Is proper Rx format used (i.e. *generic law)?*		
Are generic substitutions properly documented?		
10. Date of last inventory:		
11. Are federal DEA order forms properly kept?		
12. Pharmacy documents (*orders, invoices, sales to doctors*) reviewed?		
Any deficiencies found?		
If yes, what?		
13. Schedule V register kept?		
Entries for the last 3 months:		
14. Are Schedule V sales controlled by the pharmacist?		
15. Are current reference books and laws available?		
16. Are pharmacy technicians used?		
How many?		
Are pharmacy technicians operating within the scope of the law / regulations?		
Records of technicians and training reviewed?		
17. Are all pharmaceuticals in date and stored as required?		
18. Previous violations been corrected since last inspection?		
19. Is computer in use? Type:		
20. Are computer records properly kept?		
Including on line retrieval of Rx status?		
Printout of Rx order and refill data for each day's dispensing?		
21. Are all Rxs verified by pharmacist?		
22. Are Rx transfers properly performed?		
23. OBRA compliance?		
Are patient profiles maintained?		
Patient counseling being offered?		
24. Is practice of site consistent with permit type?		

All irregularities in number or type of Rxs on file and other comments:

Signature of owner, Pharmacist or employee

Signature of inspector

Attachment 2:
ProDUR Activity

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 2. ProDUR ANNUAL REPORT ACTIVITY

Contractor 1 (Attachment 2.1-A) 10/1/02 to 3/22/03: EDS
Contractor 2 (Attachment 2.1-B) 3/23/03 to 9/30/03: ACS State Healthcare

† During FFY 2003, contractors changed; therefore, reporting will be from each contractor responsible at the time.

From Contractor:		To Contractor:	
Fiscal Agent	EDS	Fiscal Agent	EDS
ProDUR	EDS	ProDUR	ACS State Healthcare
Prior Authorization Call Center	Health Care Excel	Prior Authorization Call Center	ACS State Healthcare
IRDP PA Call Center	Health Care Excel	IRDP phased-out, but calls taken in transition*	ACS State Healthcare
PDL Program & PDL PA	--	PDL Program & PDL PA	ACS State Healthcare
RetroDUR	EDS	RetroDUR	ACS State Healthcare
RetroDUR Studies	MED-STAT		

***ACS State Healthcare Call Center took calls for the other programs (Info only, Regular PA, IRDP) in addition to the PDL PA activity calls as contractors and programs transitioned.**

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 2.1-A ProDUR ACTIVITY

Contractor: EDS

Reporting Dates: 10/1/02 - 02/07/03

Summary by DUR Screen or Problem Category

DUR Screen	# Alerts	% of All DUR Alerts	# Overrides	# Cancellations	# Non-Responses	Cancel & No Response	% Cancel / Problem Alert	% Cancel / Total Alerts
DD – Drug-Drug	7,833	1.2%	6,351	2	1,480	1,482	18.9%	0.2%
ER – Early Refill	28,461	4.4%	26,606	0	2,152	2,152	7.6%	0.3%
HD – High Dose	220,951	33.9%	192,353	28	28,570	28,598	12.9%	4.4%
LR – Under use	98,194	15.1%	83,500	8	14,686	14,694	15.0%	2.3%
MC – Drug-Disease	106	0.0%	99	0	7	7	6.6%	0.0%
PA – Pediatric	2,724	0.4%	2,370	1	353	354	13.0%	0.1%
PG – Pregnancy	202	0.0%	192	0	10	10	5.0%	0.0%
TD – Therapeutic Duplic.	293,874	45.0%	238,729	29	55,116	55,145	18.8%	8.5%
TOTAL	**652,345**		**550,200**	**68**	**102,374**	**102,442**	**15.7%**	15.7%

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 2.1-B. **ProDUR ACTIVITY**

Contractor: ACS State Healthcare

Reporting Dates: 03/23/03 - 09/30/03

State Healthcare Solutions, PBM Group

ALL DRUG CONFLICT CODES SUMMARY

ACS ProDUR SUMMARY REPORT

Summary by ProDUR Conflict Screening Code or Problem Category

DRUG CONFLICT CODE TOTALS	TOTAL CLAIMS	TOTAL ALERTS	% ALERTS HIT	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	% OVER-RIDES
DRUG-DRUG INTERACTION (DD)	2,713,049	121,934	**4.5%**	3,019	5,292	113,623	**93.2%**
EARLY REFILL (ER)	2,841,741	548,681	**19.3%**	252,084	181,715	114,882	**20.9%**
HIGH DOSE ALERT (HD)	2,789,531	193,036	**6.9%**	24,036	54,511	114,489	**59.3%**
INGREDIENT DUPLICATION (ID)	2,708,583	138,561	**5.1%**	10,631	14,288	113,642	**82.0%**
LOW DOSE ALERT (LD)	2,716,609	127,017	**4.7%**	7,396	6,392	113,229	**89.1%**
EXCESSIVE DURATION ALERT	2,262,637	101,648	**4.5%**	364	249	101,035	**99.4%**
DRUG-AGE PRECAUTION (PA)	2,519,211	115,598	**4.6%**	2,592	2,384	110,622	**95.7%**
DRUG-GENDER ALERT	1,024,441	69,509	**6.8%**	101	63	69,345	**99.8%**
THERAPEUTIC DUPLICATION (TD)	2,826,083	319,212	**11.3%**	134,645	69,904	114,663	**35.9%**
GRAND TOTAL	**22,401,885**	**1,735,196**	**7.7%**	**434,868**	**334,798**	**965,530**	**55.6%**

ATTACHMENT 2.1-B --continued-- ProDUR ACTIVITY

ACS ProDUR REPORT – INDIANA MEDICAID

Detail ProDUR Activity Report: DUR Conflict Code by Therapeutic Class

State Healthcare Solutions, PBM Group

DRUG CONFLICT CODE: DRUG-DRUG INTERACTION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	CLASS NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H2G	ANTI-PSYCHOTICS,PHE	994	27	967	211	9,330
H2S	SELECTIVE SEROTONIN	803	215	588	22,553	140,956
S2B	NSAIDS, CYCLOOXYGEN	609	41	568	1,819	64,269
H6A	ANTIPARKINSONISM DR	583	509	74	213	16,231
H4B	ANTICONVULSANTS	373	328	45	6,093	227,543
H7T	ANTIPSYCHOTICS,ATYP	346	33	313	3,217	147,456
H3A	ANALGESICS,NARCOTIC	326	42	284	33,394	288,588
J7C	BETA-ADRENERGIC BLO	285	43	242	360	31,578
J5D	BETA-ADRENERGIC AGE	284	84	200	1,267	85,428
M4E	LIPOTROPICS	268	34	234	1,443	51,910
M9L	ORAL ANTICOAGULANTS	240	198	42	479	46,195
H2F	ANTI-ANXIETY DRUGS	178	87	91	1,456	68,417
H2U	TRICYCLIC ANTIDEPRE	153	77	76	3,704	32,985
H7B	ALPHA-2 RECEPTOR AN	152	10	142	2,866	25,004
R1M	LOOP DIURETICS	121	37	84	610	44,974
W1Q	QUINOLONES	114	2	112	62	11,576
A4D	HYPOTENSIVES, ACE I	110	30	80	505	38,755
H7C	SEROTONIN-NOREPINEP	102	49	53	7,002	35,959
C4G	INSULINS	99	73	26	482	54,541
Z2A	ANTIHISTAMINES	97	59	38	858	75,650
W3B	ANTIFUNGAL AGENTS	94	5	89	54	7,288
C1D	POTASSIUM REPLACEME	93	60	33	180	23,572
H7E	SEROTONIN-2 ANTAGON	80	61	19	2,601	34,885
Z2E	IMMUNOSUPPRESSIVES	72	68	4	83	8,647
C4K	HYPOGLYCEMICS, INSU	66	41	25	238	20,737
H3F	ANTIMIGRAINE PREPAR	61	5	56	995	20,112
P5A	GLUCOCORTICOIDS	60	52	8	431	37,172
W1O	OXAZOLIDINONES	57	1	56	1	283
H7O	ANTIPSYCHOTICS,DOPA	54	2	52	163	5,842
A9A	CALCIUM CHANNEL BLO	53	14	39	556	30,053
H6H	SKELETAL MUSCLE REL	53	15	38	870	53,262
C6Z	MULTIVITAMIN PREPAR	51	35	16	117	20,036
R1L	POTASSIUM SPARING D	49	24	25	271	6,830
D6S	LAXATIVES AND CATHA	45	41	4	1,383	81,205
J5G	BETA-ADRENERGICS AN	45	25	20	780	18,544
H3D	ANALGESIC/ANTIPYRET	43	27	16	159	14,943
C3B	IRON REPLACEMENT	42	25	17	151	17,198
D4K	GASTRIC ACID SECRET	42	29	13	929	98,008
H7D	NOREPINEPHRINE AND	42	25	17	2,508	25,233
B3J	EXPECTORANTS	39	5	34	258	19,896
H2M	ANTI-MANIA DRUGS	39	22	17	52	5,067
P3A	THYROID HORMONES	38	21	17	156	27,590
H3T	NARCOTIC ANTAGONIST	36	0	36	0	753
W5J	ANTIVIRALS, HIV-SPE	34	28	6	69	3,040
A1A	DIGITALIS GLYCOSIDE	33	14	19	184	14,505
Q6G	MIOTICS/OTHER INTRA	31	27	4	541	18,706
A4F	HYPOTENSIVES,ANGIOT	30	22	8	310	14,831

DRUG CONFLICT CODE: DRUG-DRUG INTERACTION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	THERAPEUTIC CLASS NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
A4B	HYPOTENSIVES,SYMPAT	28	10	18	427	17,353
J9A	INTESTINAL MOTILITY	28	20	8	575	15,264
G8A	CONTRACEPTIVES,ORAL	26	14	12	94	11,110
W1D	MACROLIDES	23	1	22	26	5,837
H3E	ANALGESIC/ANTIPYRET	21	17	4	1,118	51,212
R1S	URINARY PH MODIFIER	21	0	21	5	689
A2A	ANTIARRHYTHMICS	20	5	15	21	2,559
G1A	ESTROGENIC AGENTS	20	18	2	105	11,492
W2A	ABSORBABLE SULFONAM	20	4	16	205	5,453
B3K	COUGH AND/OR COLD P	19	16	3	749	28,738
D4B	ANTACIDS	18	10	8	81	7,064
A1B	XANTHINES	17	6	11	75	4,410
H2E	SEDATIVE-HYPNOTICS,	16	9	7	608	19,205
R1H	POTASSIUM SPARING D	16	9	7	47	4,741
C1F	CALCIUM REPLACEMENT	15	11	4	80	10,111
H6J	ANTIEMETIC/ANTIVERT	14	7	7	221	15,392
H2D	BARBITURATES	13	9	4	32	5,027
R1A	URINARY TRACT ANTIS	13	12	1	112	13,050
H7R	ANTIPSYCH,DOPAMINE	12	4	8	4	115
Q5P	TOPICAL ANTI-INFLAM	12	12	0	152	12,833
R1E	CARBONIC ANHYDRASE	12	2	10	7	694
M9P	PLATELET AGGREGATIO	11	5	6	72	11,079
Q7P	NASAL ANTI-INFLAMMA	11	9	2	337	16,351
A4K	ACE INHIBITOR/CALCI	10	6	4	115	4,085
H2V	TX FOR ATTENTION DE	10	6	4	438	19,746
H6B	ANTIPARKINSONISM DR	10	6	4	37	6,385
H7J	MAOIS - NON-SELECTI	10	2	8	0	73
A4Y	HYPOTENSIVES,MISCEL	9	7	2	102	2,062
H2X	TRICYCLIC ANTIDEPRE	8	3	5	10	323
H7P	ANTIPSYCHOTICS,DOPA	8	3	5	21	1,603
H7X	ANTIPSYCHOTICS, ATY	8	4	4	33	4,686
J7A	ALPHA/BETA-ADRENERG	8	5	3	38	4,005
W5C	ANTIVIRALS, HIV-SPE	8	7	1	7	830
C4N	HYPOGLYCEMICS, INSU	7	2	5	107	12,290
R1F	THIAZIDE AND RELATE	7	3	4	123	11,675
C4L	HYPOGLYCEMICS, BIGU	6	2	4	114	15,358
C6F	PRENATAL VITAMIN PR	6	5	1	402	15,350
L1B	ACNE AGENTS,SYSTEMI	6	0	6	1	101
W1A	PENICILLINS	6	2	4	396	15,089
W1F	AMINOGLYCOSIDES	6	0	6	6	640
A7B	VASODILATORS,CORONA	5	0	5	1,482	25,537
D6D	ANTIDIARRHEALS	5	3	2	84	6,485
D7L	BILE SALT SEQUESTRA	5	0	5	6	1,766
G2A	PROGESTATIONAL AGEN	5	2	3	27	2,267
H7Y	TX FOR ATTENTION DE	5	2	3	166	8,138
J7B	ALPHA-ADRENERGIC BL	5	1	4	57	3,081
V1B	ANTIMETABOLITES	5	4	1	20	1,567

DRUG CONFLICT CODE: DRUG-DRUG INTERACTION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
V1T	SELECTIVE ESTROGEN	5	0	5	6	764
W5L	ANTIVIRALS, HIV-SPE	5	2	3	4	463
C4M	HYPOGLYCEMICS, ALPH	4	0	4	3	471
C7A	HYPERURICEMIA TX -	4	3	1	16	2,535
G8F	CONTRACEPTIVES,TRAN	4	3	1	50	6,931
J5B	ADRENERGICS, AROMAT	4	3	1	42	12,068
V1F	ANTINEOPLASTICS,MIS	4	0	4	4	315
A4A	HYPOTENSIVES,VASODI	3	2	1	36	2,081
C1P	PHOSPHATE REPLACEME	3	0	3	0	49
C6M	FOLIC ACID PREPARAT	3	3	0	29	4,734
D4E	ANTI-ULCER PREPARAT	3	2	1	13	2,020
F2A	DRUGS TO TREAT IMPO	3	0	3	0	129
H2W	TRICYCLIC ANTIDEPRE	3	3	0	29	591
J2A	BELLADONNA ALKALOID	3	3	0	23	2,026
J2D	ANTICHOLINERGICS/AN	3	3	0	20	2,134
Q5F	TOPICAL ANTIFUNGALS	3	3	0	219	16,198
W1C	TETRACYCLINES	3	2	1	27	3,572
W2F	NITROFURAN DERIVATI	3	0	3	23	2,646
A1D	GENERAL BRONCHODILA	2	2	0	710	8,145
C1A	ELECTROLYTE DEPLETE	2	2	0	64	5,869
C3C	ZINC REPLACEMENT	2	0	2	4	752
C6G	GERIATRIC VITAMIN P	2	2	0	3	249
H7N	SMOKING DETERRENTS,	2	2	0	5	492
H7W	ANTI-NARCOLEPSY/ANT	2	0	2	0	31
J5F	ANAPHYLAXIS THERAPY	2	0	2	3	276
J9B	ANTISPASMODIC AGENT	2	0	2	1	44
M9S	HEMORRHEOLOGIC AGEN	2	0	2	15	1,427
P1B	SOMATOSTATIC AGENTS	2	2	0	6	86
Q6J	MYDRIATICS	2	1	1	9	414
W1W	CEPHALOSPORINS - 1S	2	0	2	19	5,897
W3A	ANTIFUNGAL ANTIBIOT	2	1	1	14	1,676
W4E	ANAEROBIC ANTIPROTO	2	0	2	9	2,890
W5A	ANTIVIRALS, GENERAL	2	1	1	16	3,033
W5K	ANTIVIRALS, HIV-SPE	2	2	0	2	484
X2B	SYRINGES AND ACCESS	2	2	0	0	944
B0A	GENERAL INHALATION	1	0	1	12	585
C1H	MAGNESIUM SALTS REP	1	0	1	7	889
C6B	VITAMIN B PREPARATI	1	1	0	24	2,712
G1B	ESTROGEN/ANDROGEN C	1	1	0	5	805
H7U	ANTIPSYCHOTICS, DOP	1	0	1	8	740
J8A	ANOREXIC AGENTS	1	0	1	0	99
L5G	ROSACEA AGENTS, TOP	1	1	0	4	502
P1F	PITUITARY SUPPRESSI	1	0	1	2	393
P3L	ANTITHYROID PREPARA	1	1	0	3	494
P4L	BONE RESORPTION INH	1	1	0	214	18,280
P5S	MINERALOCORTICOIDS	1	1	0	7	671
Q3A	RECTAL PREPARATIONS	1	1	0	23	1,484

DRUG CONFLICT CODE: DRUG-DRUG INTERACTION

REPORTING DATES: 03/23/03 - 09/30/03

	THERAPEUTIC CLASS CODE/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
Q3D	HEMORRHOIDAL PREPAR	1	1	0	9	372
Q5K	TOPICAL IMMUNOSUPPR	1	0	1	20	2,001
Q5W	TOPICAL ANTIBIOTICS	1	1	0	59	7,983
Q6I	EYE ANTIBIOTIC-CORT	1	1	0	5	829
Q6T	ARTIFICIAL TEARS	1	1	0	93	6,703
Q6W	OPHTHALMIC ANTIBIOT	1	1	0	30	2,568
W2G	CHEMOTHERAPEUTICS,	1	0	1	2	593
W4A	ANTIMALARIAL DRUGS	1	0	1	32	3,105
Z4B	LEUKOTRIENE RECEPTO	1	1	0	61	10,301
DRUG-DRUG INTERACTION TOTALS		**8,311**	**3,019**	**5,292**	**113,623**	**2,713,049**

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DRUG CONFLICT CODE: EARLY REFILL

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H4B	ANTICONVULSANTS	35,157	25,981	9,172	6,093	227,543
H7T	ANTIPSYCHOTICS,ATYP	23,032	12,242	10,774	3,217	147,456
H2S	SELECTIVE SEROTONIN	22,307	13,396	8,909	22,553	140,956
H3A	ANALGESICS,NARCOTIC	22,254	11,679	10,567	33,394	288,588
D4K	GASTRIC ACID SECRET	20,176	11,045	9,131	929	98,008
H2F	ANTI-ANXIETY DRUGS	16,614	9,462	7,152	1,456	68,417
R1M	LOOP DIURETICS	13,386	7,041	6,344	610	44,974
A4D	HYPOTENSIVES, ACE I	11,081	5,749	5,332	505	38,755
J5D	BETA-ADRENERGIC AGE	10,891	7,014	3,877	1,267	85,428
C4G	INSULINS	10,281	6,235	4,046	482	54,541
Z2A	ANTIHISTAMINES	10,182	5,723	4,459	858	75,650
J7C	BETA-ADRENERGIC BLO	9,628	5,075	4,551	360	31,578
M4E	LIPOTROPICS	9,015	4,644	4,371	1,443	51,910
S2B	NSAIDS, CYCLOOXYGEN	8,150	4,251	3,899	1,819	64,269
D6S	LAXATIVES AND CATHA	7,952	5,140	2,812	1,383	81,205
A9A	CALCIUM CHANNEL BLO	7,610	3,965	3,645	556	30,053
P3A	THYROID HORMONES	7,575	4,161	3,414	156	27,590
M9L	ORAL ANTICOAGULANTS	7,226	5,517	1,709	479	46,195
C1D	POTASSIUM REPLACEME	6,766	3,658	3,108	180	23,572
C4K	HYPOGLYCEMICS, INSU	6,131	3,448	2,683	238	20,737
H6H	SKELETAL MUSCLE REL	5,718	3,240	2,475	870	53,262
C6Z	MULTIVITAMIN PREPAR	5,377	3,086	2,291	117	20,036
H3D	ANALGESIC/ANTIPYRET	4,774	2,599	2,175	159	14,943
P5A	GLUCOCORTICOIDS	4,768	2,893	1,874	431	37,172
H7E	SEROTONIN-2 ANTAGON	4,455	3,434	1,019	2,601	34,885
A4B	HYPOTENSIVES,SYMPAT	4,040	2,129	1,910	427	17,353
H2U	TRICYCLIC ANTIDEPRE	3,913	2,621	1,291	3,704	32,985
H2E	SEDATIVE-HYPNOTICS,	3,912	2,273	1,639	608	19,205
C4L	HYPOGLYCEMICS, BIGU	3,807	2,118	1,689	114	15,358
H3E	ANALGESIC/ANTIPYRET	3,717	2,082	1,635	1,118	51,212
R1F	THIAZIDE AND RELATE	3,659	2,019	1,640	123	11,675
A7B	VASODILATORS,CORONA	3,634	1,913	1,719	1,482	25,537
C1F	CALCIUM REPLACEMENT	3,463	1,911	1,552	80	10,111
A1A	DIGITALIS GLYCOSIDE	3,417	1,780	1,637	184	14,505
C4N	HYPOGLYCEMICS, INSU	3,289	1,712	1,577	107	12,290
G8A	CONTRACEPTIVES,ORAL	3,222	1,660	1,562	94	11,110
M9P	PLATELET AGGREGATIO	3,149	1,718	1,431	72	11,079
G1A	ESTROGENIC AGENTS	3,079	1,622	1,457	105	11,492
H7C	SEROTONIN-NOREPINEP	3,036	1,932	1,103	7,002	35,959
H2V	TX FOR ATTENTION DE	3,032	1,844	1,188	438	19,746
P4L	BONE RESORPTION INH	2,914	1,590	1,324	214	18,280
R1A	URINARY TRACT ANTIS	2,825	1,580	1,245	112	13,050
C3B	IRON REPLACEMENT	2,746	1,584	1,162	151	17,198
Z4B	LEUKOTRIENE RECEPTO	2,728	1,381	1,347	61	10,301
H7B	ALPHA-2 RECEPTOR AN	2,703	1,816	887	2,866	25,004
H7D	NOREPINEPHRINE AND	2,426	1,627	799	2,508	25,233
J5B	ADRENERGICS, AROMAT	2,404	1,431	973	42	12,068

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ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: EARLY REFILL

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
A4F	HYPOTENSIVES,ANGIOT	2,365	1,241	1,124	310	14,831
H6B	ANTIPARKINSONISM DR	2,317	1,230	1,087	37	6,385
R1L	POTASSIUM SPARING D	2,168	1,200	968	271	6,830
H6A	ANTIPARKINSONISM DR	1,936	1,384	552	213	16,231
J9A	INTESTINAL MOTILITY	1,908	1,113	795	575	15,264
G8F	CONTRACEPTIVES,TRAN	1,901	996	905	50	6,931
H7Y	TX FOR ATTENTION DE	1,870	1,023	847	166	8,138
Q7P	NASAL ANTI-INFLAMMA	1,812	1,111	701	337	16,351
J1B	CHOLINESTERASE INHI	1,802	1,037	765	59	7,612
R1H	POTASSIUM SPARING D	1,562	851	711	47	4,741
J5G	BETA-ADRENERGICS AN	1,451	1,091	360	780	18,544
Q6G	MIOTICS/OTHER INTRA	1,427	938	489	541	18,706
H7X	ANTIPSYCHOTICS, ATY	1,399	767	632	33	4,686
B3J	EXPECTORANTS	1,354	737	617	258	19,896
C6M	FOLIC ACID PREPARAT	1,311	729	582	29	4,734
H2D	BARBITURATES	1,254	709	545	32	5,027
H2M	ANTI-MANIA DRUGS	1,246	707	539	52	5,067
H2G	ANTI-PSYCHOTICS,PHE	1,239	652	587	211	9,330
H7O	ANTIPSYCHOTICS,DOPA	1,232	637	595	163	5,842
C7A	HYPERURICEMIA TX -	974	501	473	16	2,535
C6C	VITAMIN C PREPARATI	959	534	425	6	2,437
W2A	ABSORBABLE SULFONAM	942	500	442	205	5,453
C6F	PRENATAL VITAMIN PR	940	534	406	402	15,350
Q5F	TOPICAL ANTIFUNGALS	934	517	417	219	16,198
A1B	XANTHINES	913	502	411	75	4,410
Q5P	TOPICAL ANTI-INFLAM	905	567	338	152	12,833
J7A	ALPHA/BETA-ADRENERG	893	478	415	38	4,005
J7B	ALPHA-ADRENERGIC BL	865	463	402	57	3,081
W4A	ANTIMALARIAL DRUGS	850	443	407	32	3,105
H6J	ANTIEMETIC/ANTIVERT	846	500	346	221	15,392
A1D	GENERAL BRONCHODILA	843	461	382	710	8,145
Q9B	BENIGN PROSTATIC HY	832	485	347	34	3,020
P2B	ANTIDIURETIC AND VA	826	432	394	25	2,372
D4B	ANTACIDS	731	396	335	81	7,064
C6E	VITAMIN E PREPARATI	730	438	292	13	2,322
Z2E	IMMUNOSUPPRESSIVES	719	566	153	83	8,647
C1A	ELECTROLYTE DEPLETE	702	429	273	64	5,869
U6N	VEHICLES	667	345	322	53	5,168
W1C	TETRACYCLINES	652	338	314	27	3,572
A4K	ACE INHIBITOR/CALCI	648	343	305	115	4,085
B3K	COUGH AND/OR COLD P	636	403	233	749	28,738
A2A	ANTIARRHYTHMICS	611	327	284	21	2,559
Q5W	TOPICAL ANTIBIOTICS	610	338	272	59	7,983
W1A	PENICILLINS	599	322	277	396	15,089
C6B	VITAMIN B PREPARATI	583	326	257	24	2,712
G8C	CONTRACEPTIVES,INJE	537	294	243	38	2,393
A4A	HYPOTENSIVES,VASODI	536	299	237	36	2,081

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DRUG CONFLICT CODE: EARLY REFILL

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
W2F	NITROFURAN DERIVATI	484	282	202	23	2,646
C6L	VITAMIN B12 PREPARA	462	244	218	70	2,613
Q6T	ARTIFICIAL TEARS	445	253	192	93	6,703
A4Y	HYPOTENSIVES,MISCEL	436	229	207	102	2,062
G2A	PROGESTATIONAL AGEN	431	234	197	27	2,267
W1Q	QUINOLONES	423	225	197	62	11,576
V1B	ANTIMETABOLITES	413	215	198	20	1,567
D6D	ANTIDIARRHEALS	411	220	191	84	6,485
H3F	ANTIMIGRAINE PREPAR	406	291	115	995	20,112
W1W	CEPHALOSPORINS - 1S	367	207	160	19	5,897
C3C	ZINC REPLACEMENT	351	186	165	4	752
W3B	ANTIFUNGAL AGENTS	349	209	140	54	7,288
Q3S	LAXATIVES, LOCAL/RE	347	276	71	106	9,277
L0B	TOPICAL/MUCOUS MEMB	345	219	126	20	9,029
W3A	ANTIFUNGAL ANTIBIOT	336	182	154	14	1,676
D4E	ANTI-ULCER PREPARAT	328	169	159	13	2,020
J2D	ANTICHOLINERGICS/AN	325	171	154	20	2,134
J2A	BELLADONNA ALKALOID	312	162	150	23	2,026
V1E	STEROID ANTINEOPLAS	293	159	134	21	1,980
Q5H	TOPICAL LOCAL ANEST	271	151	120	60	2,010
M9S	HEMORRHEOLOGIC AGEN	264	135	129	15	1,427
Q6P	EYE ANTIINFLAMMATOR	248	139	109	31	2,111
N1B	HEMATINICS,OTHER	239	138	101	5	1,760
W5A	ANTIVIRALS, GENERAL	239	138	101	16	3,033
Q5S	TOPICAL SULFONAMIDE	234	119	115	5	1,892
C6H	PEDIATRIC VITAMIN P	225	116	109	19	1,595
H0E	AGENTS TO TREAT MUL	222	134	88	12	2,018
Q5R	TOPICAL ANTIPARASIT	219	110	109	9	1,591
Q6W	OPHTHALMIC ANTIBIOT	219	115	104	30	2,568
D8A	PANCREATIC ENZYMES	212	116	96	14	1,367
W5J	ANTIVIRALS, HIV-SPE	212	186	26	69	3,040
W1D	MACROLIDES	208	131	77	26	5,837
D6E	IRRITABLE BOWEL SYN	206	114	92	5	1,227
Q5K	TOPICAL IMMUNOSUPPR	206	105	101	20	2,001
C6D	VITAMIN D PREPARATI	204	114	90	3	936
S2A	COLCHICINE	204	111	93	9	694
W8F	IRRIGANTS	198	140	58	16	4,804
H7P	ANTIPSYCHOTICS,DOPA	193	127	66	21	1,603
V1T	SELECTIVE ESTROGEN	193	101	92	6	764
D1D	DENTAL AIDS AND PRE	182	92	90	123	2,033
P5S	MINERALOCORTICOIDS	181	92	89	7	671
M9K	HEPARIN AND RELATED	174	89	85	3	2,290
Z2G	IMMUNOMODULATORS	173	87	86	12	2,002
D7L	BILE SALT SEQUESTRA	166	90	76	6	1,766
C6T	VITAMIN B1 PREPARAT	155	81	74	3	507
W5G	HEPATITIS C TREATME	145	77	68	7	675
R1E	CARBONIC ANHYDRASE	140	80	60	7	694

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DRUG CONFLICT CODE: EARLY REFILL

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H7U	ANTIPSYCHOTICS, DOP	139	79	60	8	740
J2B	ANTICHOLINERGICS,QU	139	85	54	11	1,008
Q6R	EYE ANTIHISTAMINES	138	69	69	28	2,087
S2J	ANTI-INFLAMMATORY T	132	79	53	6	892
L2A	EMOLLIENTS	130	69	61	25	2,325
W5L	ANTIVIRALS, HIV-SPE	124	69	55	4	463
Z2F	MAST CELL STABILIZE	124	62	62	11	852
H3T	NARCOTIC ANTAGONIST	118	65	53	0	753
D6F	DRUG TX-CHRONIC INF	116	64	52	16	1,670
H6C	ANTITUSSIVES,NON-NA	112	62	50	24	2,180
W4E	ANAEROBIC ANTIPROTO	106	61	45	9	2,890
C7D	METABOLIC DEFICIENC	104	53	51	0	338
J3A	SMOKING DETERRENT A	102	53	49	31	2,428
P3L	ANTITHYROID PREPARA	101	54	47	3	494
P1F	PITUITARY SUPPRESSI	100	55	45	2	393
Q8W	EAR PREPARATIONS,AN	100	50	50	1	644
R1S	URINARY PH MODIFIER	99	60	39	5	689
W1Y	CEPHALOSPORINS - 3R	97	51	46	12	1,336
W5K	ANTIVIRALS, HIV-SPE	97	57	40	2	484
U6H	SOLVENTS	94	51	43	0	925
U6A	PHARMACEUTICAL ADJU	93	47	46	1	203
G1B	ESTROGEN/ANDROGEN C	90	50	40	5	805
Q4K	VAGINAL ESTROGEN PR	90	50	40	17	922
W5C	ANTIVIRALS, HIV-SPE	90	61	29	7	830
C1B	SODIUM/SALINE PREPA	89	61	28	1	2,176
C6Q	VITAMIN B6 PREPARAT	84	45	39	1	354
F1A	ANDROGENIC AGENTS	84	58	26	10	694
H2W	TRICYCLIC ANTIDEPRE	84	65	19	29	591
C4M	HYPOGLYCEMICS, ALPH	83	48	35	3	471
V1F	ANTINEOPLASTICS,MIS	81	45	36	4	315
W5I	ANTIVIRALS, HIV-SPE	80	40	40	0	220
D4G	GASTRIC ENZYMES	79	42	37	0	272
B0A	GENERAL INHALATION	78	39	39	12	585
D2A	FLUORIDE PREPARATIO	78	40	38	11	802
J5E	SYMPATHOMIMETIC AGE	78	41	37	5	1,288
C1H	MAGNESIUM SALTS REP	72	39	33	7	889
W1X	CEPHALOSPORINS - 2N	66	33	33	4	1,266
W5M	ANTIVIRALS, HIV-SPE	66	36	30	3	304
M4G	HYPERGLYCEMICS	65	33	32	11	771
G9B	CONTRACEPTIVES, INT	64	36	28	4	556
H0A	LOCAL ANESTHETICS	63	32	31	4	591
V1A	ALKYLATING AGENTS	62	32	30	0	331
W1K	LINCOSAMIDES	62	32	30	2	1,299
L5A	KERATOLYTICS	60	37	23	15	1,087
Q6J	MYDRIATICS	60	31	29	9	414
D9A	AMMONIA INHIBITORS	59	31	28	2	411
D4N	ANTIFLATULENTS	58	30	28	2	742

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DRUG CONFLICT CODE: EARLY REFILL

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
Q3A	RECTAL PREPARATIONS	58	33	25	23	1,484
W2G	CHEMOTHERAPEUTICS,	58	38	20	2	593
J5H	ADRENERGIC VASOPRES	57	38	19	2	458
Q6U	OPHTHALMIC MAST CEL	54	35	19	5	345
C6N	NIACIN PREPARATIONS	51	27	24	1	122
J1A	PARASYMPATHETIC AGE	50	28	22	4	612
L5H	ACNE AGENTS,TOPICAL	50	26	24	6	927
L9B	VITAMIN A DERIVATIV	48	26	22	5	1,093
Q8F	OTIC PREPARATIONS,A	48	24	24	3	301
L5E	ANTISEBORRHEIC AGEN	45	23	22	11	797
Q6S	EYE SULFONAMIDES	44	22	22	1	227
L5F	ANTIPSORIATICS AGEN	40	20	20	15	690
Q5V	TOPICAL ANTIVIRALS	40	21	19	6	581
S2I	ANTI-INFLAMMATORY,	40	20	20	4	265
J5F	ANAPHYLAXIS THERAPY	38	19	19	3	276
Q6Y	EYE PREPARATIONS, M	38	20	18	6	1,099
W2E	ANTI-MYCOBACTERIUM	38	19	19	5	265
C0D	ANTI-ALCOHOLIC PREP	36	18	18	0	89
P1A	GROWTH HORMONES	36	21	15	6	197
H7N	SMOKING DETERRENTS,	34	30	4	5	492
Q6I	EYE ANTIBIOTIC-CORT	34	17	17	5	829
Q7E	NASAL ANTIHISTAMINE	32	25	7	39	1,157
W1F	AMINOGLYCOSIDES	32	24	8	6	640
Q7A	NOSE PREPARATIONS,	30	23	7	5	472
V1Q	ANTINEOPLASTIC SYST	29	18	11	0	111
D7A	BILE SALTS	28	16	12	5	705
L5G	ROSACEA AGENTS, TOP	28	14	14	4	502
R5A	URINARY TRACT ANEST	28	14	14	6	1,098
C1W	ELECTROLYTE MAINTEN	26	13	13	1	237
H7S	ANTIPSYCHOTICS,DOPA	26	16	10	2	232
R1R	URICOSURIC AGENTS	25	13	12	0	64
Q8R	EAR PREPARATIONS,EA	24	12	12	0	101
V1I	CHEMOTHERAPY RESCUE	24	13	11	1	166
W1J	VANCOMYCIN AND DERI	24	16	7	8	547
W4P	ANTILEPROTICS	24	12	12	0	105
H7R	ANTIPSYCH,DOPAMINE	22	12	10	4	115
Q5B	TOPICAL PREPARATION	22	15	7	1	209
R4A	KIDNEY STONE AGENTS	21	11	10	0	32
C6G	GERIATRIC VITAMIN P	20	10	10	3	249
H2X	TRICYCLIC ANTIDEPRE	19	13	6	10	323
N1C	LEUKOCYTE (WBC) STI	18	9	9	0	91
P1B	SOMATOSTATIC AGENTS	18	9	9	6	86
Q2C	OPHTHALMIC ANTI-INF	18	9	9	0	129
B3A	MUCOLYTICS	17	9	8	1	342
Q3D	HEMORRHOIDAL PREPAR	17	13	4	9	372
L1B	ACNE AGENTS,SYSTEMI	16	9	7	1	101
N1D	PLATELET REDUCING A	16	10	6	0	165

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DRUG CONFLICT CODE: EARLY REFILL

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
Q5A	TOPICAL PREPARATION	16	8	8	0	48
C0B	WATER	14	7	7	0	148
H2A	CENTRAL NERVOUS SYS	14	7	7	13	210
L9C	HYPOPIGMENTATION AG	14	7	7	0	72
Q7Y	NOSE PREPARATIONS,	14	7	7	1	102
D1A	PERIODONTAL COLLAGE	12	6	6	2	93
L6A	IRRITANTS/COUNTER-I	12	7	5	0	526
P1P	LHRH(GNRH)AGNST PIT	12	7	5	31	352
V1J	ANTIANDROGENIC AGEN	12	6	6	1	75
W1G	ANTITUBERCULAR ANTI	12	6	6	1	222
C6K	VITAMIN K PREPARATI	10	5	5	2	120
H7J	MAOIS - NON-SELECTI	10	5	5	0	73
L0C	DIABETIC ULCER PREP	10	5	5	1	233
Q8H	EAR PREPARATIONS,LO	10	5	5	0	98
A7C	VASODILATORS,PERIPH	9	5	4	0	55
C5K	IV SOLUTIONS: DEXTR	9	9	0	0	121
C0K	BICARBONATE PRODUCI	8	5	3	0	90
H6I	AMYOTROPHIC LATERAL	8	5	3	0	24
L3A	PROTECTIVES	8	4	4	0	59
M4A	BLOOD SUGAR DIAGNOS	8	4	4	0	1,744
M9D	ANTIFIBRINOLYTIC AG	8	4	4	0	13
Q4F	VAGINAL ANTIFUNGALS	8	5	3	8	668
Q7H	NASAL MAST CELL STA	8	4	4	0	9
R5B	URINARY TRACT ANALG	8	6	2	2	221
W7B	VIRAL/TUMORIGENIC V	8	4	4	0	43
W7K	ANTISERA	8	4	4	0	50
C8A	METALLIC POISON,AGE	6	5	1	0	43
P1M	LHRH(GNRH) AGONIST	6	3	3	1	151
Q4B	VAGINAL ANTISEPTICS	6	3	3	0	15
W5F	HEPATITIS B TREATME	6	3	3	0	39
C7B	DECARBOXYLASE INHIB	5	3	2	0	52
Q8B	EAR PREPARATIONS, M	5	3	2	5	201
D6C	IRRITABLE BOWEL SYN	4	3	1	0	30
M0E	ANTIHEMOPHILIC FACT	4	4	0	0	80
Q3B	RECTAL/LOWER BOWEL	4	4	0	0	28
Q6H	EYE LOCAL ANESTHETI	4	2	2	0	11
W1Z	CEPHALOSPORINS - 4T	4	2	2	0	85
L1A	ANTIPSORIATIC AGENT	3	2	1	0	29
A4C	HYPOTENSIVES,GANGLI	2	1	1	0	3
A7H	VASOACTIVE NATRIURE	2	1	1	0	1
B1B	PULMONARY ANTI-HTN,	2	1	1	0	17
B1C	PULMONARY ANTIHYPER	2	1	1	0	4
D7D	DRUGS TO TREAT HERE	2	1	1	0	2
L7A	SHAMPOOS/LOTION	2	1	1	1	24
L9A	TOPICAL AGENTS,MISC	2	1	1	2	141
M4B	IV FAT EMULSIONS	2	1	1	0	54
Q4S	VAGINAL SULFONAMIDE	2	1	1	0	9

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ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: EARLY REFILL

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE/NAME		TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
Q4W	VAGINAL ANTIBIOTICS	2	1	1	0	147
S2C	GOLD SALTS	2	1	1	0	30
U6W	BULK CHEMICALS	2	2	0	1	266
W1S	CARBAPENEMS (THIENA	2	1	1	1	141
W5D	ANTIVIRAL MONOCLONA	2	2	0	0	148
Y0A	DURABLE MEDICAL EQU	2	1	1	0	17
Y4B	CATHETERS AND RELAT	2	1	1	0	21
W4L	ANTHELMINTICS	1	1	0	0	76
EARLY REFILL ALERT TOTALS		**433,845**	**252,084**	**181,715**	**114,882**	**2,841,471**

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ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: HIGH DOSE ALERT

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H3A	ANALGESICS,NARCOTIC	9,834	1,153	8,681	33,394	288,588
D4K	GASTRIC ACID SECRET	5,736	1,183	4,553	929	98,008
H7T	ANTIPSYCHOTICS,ATYP	5,425	703	4,722	3,217	147,456
H3E	ANALGESIC/ANTIPYRET	4,418	1,226	3,192	1,118	51,212
S2B	NSAIDS, CYCLOOXYGEN	3,658	182	3,476	1,819	64,269
H2S	SELECTIVE SEROTONIN	3,610	2,237	1,373	22,553	140,956
H4B	ANTICONVULSANTS	3,007	2,635	372	6,093	227,543
D6S	LAXATIVES AND CATHA	2,945	1,285	1,660	1,383	81,205
H7C	SEROTONIN-NOREPINEP	2,667	1,730	937	7,002	35,959
C3B	IRON REPLACEMENT	2,075	526	1,549	151	17,198
Z2A	ANTIHISTAMINES	1,974	699	1,275	858	75,650
H6H	SKELETAL MUSCLE REL	1,517	77	1,440	870	53,262
W1Q	QUINOLONES	1,308	22	1,286	62	11,576
H6J	ANTIEMETIC/ANTIVERT	1,274	370	904	221	15,392
C1D	POTASSIUM REPLACEME	1,126	176	950	180	23,572
H2V	TX FOR ATTENTION DE	1,064	595	469	438	19,746
P4L	BONE RESORPTION INH	1,004	284	720	214	18,280
J5D	BETA-ADRENERGIC AGE	943	727	216	1,267	85,428
A9A	CALCIUM CHANNEL BLO	933	342	591	556	30,053
J5G	BETA-ADRENERGICS AN	918	781	137	780	18,544
H7B	ALPHA-2 RECEPTOR AN	915	657	258	2,866	25,004
P3A	THYROID HORMONES	740	208	532	156	27,590
Z2G	IMMUNOMODULATORS	650	71	579	12	2,002
M9L	ORAL ANTICOAGULANTS	607	169	438	479	46,195
H3D	ANALGESIC/ANTIPYRET	598	44	554	159	14,943
B3J	EXPECTORANTS	579	151	428	258	19,896
D6D	ANTIDIARRHEALS	575	73	502	84	6,485
H7D	NOREPINEPHRINE AND	566	468	98	2,508	25,233
H2E	SEDATIVE-HYPNOTICS,	561	463	98	608	19,205
R1A	URINARY TRACT ANTIS	556	78	478	112	13,050
H2F	ANTI-ANXIETY DRUGS	555	370	185	1,456	68,417
C6Z	MULTIVITAMIN PREPAR	548	64	484	117	20,036
H3F	ANTIMIGRAINE PREPAR	545	136	409	995	20,112
C1A	ELECTROLYTE DEPLETE	507	96	411	64	5,869
A4B	HYPOTENSIVES,SYMPAT	479	165	314	427	17,353
A4F	HYPOTENSIVES,ANGIOT	479	62	417	310	14,831
C4L	HYPOGLYCEMICS, BIGU	470	71	399	114	15,358
J7A	ALPHA/BETA-ADRENERG	470	13	457	38	4,005
A4D	HYPOTENSIVES, ACE I	448	30	418	505	38,755
C4K	HYPOGLYCEMICS, INSU	439	74	365	238	20,737
A1B	XANTHINES	414	67	347	75	4,410
G8A	CONTRACEPTIVES,ORAL	411	77	334	94	11,110
Q6G	MIOTICS/OTHER INTRA	406	371	35	541	18,706
W1A	PENICILLINS	401	15	386	396	15,089
P5A	GLUCOCORTICOIDS	358	266	92	431	37,172
A4K	ACE INHIBITOR/CALCI	355	80	275	115	4,085
C4N	HYPOGLYCEMICS, INSU	350	61	289	107	12,290

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ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: HIGH DOSE ALERT

REPORTING DATES: 03/23/03 - 09/30/03

	THERAPEUTIC CLASS CODE/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
A7B	VASODILATORS,CORONA	322	106	216	1,482	25,537
H6C	ANTITUSSIVES,NON-NA	311	33	278	24	2,180
Q7P	NASAL ANTI-INFLAMMA	283	252	31	337	16,351
A1D	GENERAL BRONCHODILA	282	251	31	710	8,145
D6F	DRUG TX-CHRONIC INF	260	28	232	16	1,670
M9P	PLATELET AGGREGATIO	255	30	225	72	11,079
M4E	LIPOTROPICS	252	22	230	1,443	51,910
H6A	ANTIPARKINSONISM DR	242	155	87	213	16,231
R5A	URINARY TRACT ANEST	242	9	233	6	1,098
H6B	ANTIPARKINSONISM DR	201	19	182	37	6,385
G1A	ESTROGENIC AGENTS	190	55	135	105	11,492
C6F	PRENATAL VITAMIN PR	189	76	113	402	15,350
H3T	NARCOTIC ANTAGONIST	185	5	180	0	753
G8F	CONTRACEPTIVES,TRAN	180	52	128	50	6,931
D7A	BILE SALTS	178	4	174	5	705
J5E	SYMPATHOMIMETIC AGE	177	34	143	5	1,288
Z4B	LEUKOTRIENE RECEPTO	170	17	153	61	10,301
J5B	ADRENERGICS, AROMAT	164	71	93	42	12,068
M9S	HEMORRHEOLOGIC AGEN	162	9	153	15	1,427
Q5H	TOPICAL LOCAL ANEST	158	59	99	60	2,010
H7Y	TX FOR ATTENTION DE	142	111	31	166	8,138
R1M	LOOP DIURETICS	140	23	117	610	44,974
D1D	DENTAL AIDS AND PRE	135	109	26	123	2,033
W3B	ANTIFUNGAL AGENTS	134	20	114	54	7,288
W1C	TETRACYCLINES	125	8	117	27	3,572
W1D	MACROLIDES	124	12	112	26	5,837
C6B	VITAMIN B PREPARATI	122	23	99	24	2,712
J1B	CHOLINESTERASE INHI	115	64	51	59	7,612
H2U	TRICYCLIC ANTIDEPRE	109	71	38	3,704	32,985
J3A	SMOKING DETERRENT A	106	40	66	31	2,428
H7E	SEROTONIN-2 ANTAGON	99	63	36	2,601	34,885
P5S	MINERALOCORTICOIDS	96	7	89	7	671
H7X	ANTIPSYCHOTICS, ATY	95	36	59	33	4,686
B3K	COUGH AND/OR COLD P	94	56	38	749	28,738
C1H	MAGNESIUM SALTS REP	91	4	87	7	889
J7C	BETA-ADRENERGIC BLO	89	8	81	360	31,578
D6E	IRRITABLE BOWEL SYN	83	8	75	5	1,227
C6M	FOLIC ACID PREPARAT	79	25	54	29	4,734
Q4K	VAGINAL ESTROGEN PR	79	18	61	17	922
A1A	DIGITALIS GLYCOSIDE	78	32	46	184	14,505
D4E	ANTI-ULCER PREPARAT	78	14	64	13	2,020
W1X	CEPHALOSPORINS - 2N	78	1	77	4	1,266
A4A	HYPOTENSIVES,VASODI	75	6	69	36	2,081
J2B	ANTICHOLINERGICS,QU	75	11	64	11	1,008
S2J	ANTI-INFLAMMATORY T	72	13	59	6	892
C6L	VITAMIN B12 PREPARA	71	65	6	70	2,613
D8A	PANCREATIC ENZYMES	71	10	61	14	1,367

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ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: HIGH DOSE ALERT

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
Q9B	BENIGN PROSTATIC HY	65	18	47	34	3,020
W1G	ANTITUBERCULAR ANTI	62	3	59	1	222
R1F	THIAZIDE AND RELATE	60	11	49	123	11,675
C4G	INSULINS	59	23	36	482	54,541
G2A	PROGESTATIONAL AGEN	58	11	47	27	2,267
W1Y	CEPHALOSPORINS - 3R	57	4	53	12	1,336
R5B	URINARY TRACT ANALG	56	2	54	2	221
J9A	INTESTINAL MOTILITY	53	6	47	575	15,264
W3A	ANTIFUNGAL ANTIBIOT	53	14	39	14	1,676
J2A	BELLADONNA ALKALOID	50	5	45	23	2,026
C7A	HYPERURICEMIA TX -	48	9	39	16	2,535
G9B	CONTRACEPTIVES, INT	48	7	41	4	556
W5A	ANTIVIRALS, GENERAL	46	13	33	16	3,033
R1E	CARBONIC ANHYDRASE	45	1	44	7	694
A2A	ANTIARRHYTHMICS	44	2	42	21	2,559
H2G	ANTI-PSYCHOTICS,PHE	44	12	32	211	9,330
W1K	LINCOSAMIDES	43	1	42	2	1,299
Z2E	IMMUNOSUPPRESSIVES	41	30	11	83	8,647
W5G	HEPATITIS C TREATME	40	3	37	7	675
F1A	ANDROGENIC AGENTS	38	8	30	10	694
W4A	ANTIMALARIAL DRUGS	35	3	32	32	3,105
P2B	ANTIDIURETIC AND VA	34	14	20	25	2,372
W5C	ANTIVIRALS, HIV-SPE	34	13	21	7	830
H0E	AGENTS TO TREAT MUL	33	6	27	12	2,018
W1W	CEPHALOSPORINS - 1S	32	2	30	19	5,897
R1H	POTASSIUM SPARING D	31	10	21	47	4,741
W4E	ANAEROBIC ANTIPROTO	30	0	30	9	2,890
W5J	ANTIVIRALS, HIV-SPE	29	24	5	69	3,040
H2W	TRICYCLIC ANTIDEPRE	28	15	13	29	591
H7U	ANTIPSYCHOTICS, DOP	28	0	28	8	740
A4Y	HYPOTENSIVES,MISCEL	27	6	21	102	2,062
G8C	CONTRACEPTIVES,INJE	27	23	4	38	2,393
R1S	URINARY PH MODIFIER	27	2	25	5	689
R1L	POTASSIUM SPARING D	26	3	23	271	6,830
W5K	ANTIVIRALS, HIV-SPE	26	5	21	2	484
H2A	CENTRAL NERVOUS SYS	25	15	10	13	210
J1A	PARASYMPATHETIC AGE	25	4	21	4	612
Q6R	EYE ANTIHISTAMINES	25	25	0	28	2,087
D4F	ANTI-ULCER-H.PYLORI	23	17	6	6	358
Q6P	EYE ANTIINFLAMMATOR	22	19	3	31	2,111
Q7E	NASAL ANTIHISTAMINE	22	22	0	39	1,157
D7L	BILE SALT SEQUESTRA	20	6	14	6	1,766
P3L	ANTITHYROID PREPARA	20	2	18	3	494
S2A	COLCHICINE	20	3	17	9	694
S2I	ANTI-INFLAMMATORY,	18	0	18	4	265
W2E	ANTI-MYCOBACTERIUM	16	0	16	5	265
H2D	BARBITURATES	15	8	7	32	5,027

DRUG CONFLICT CODE: HIGH DOSE ALERT

REPORTING DATES: 03/23/03 - 09/30/03

	THERAPEUTIC CLASS CODE/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
J7B	ALPHA-ADRENERGIC BL	15	0	15	57	3,081
P1F	PITUITARY SUPPRESSI	15	4	11	2	393
Q5F	TOPICAL ANTIFUNGALS	15	13	2	219	16,198
W2A	ABSORBABLE SULFONAM	15	4	11	205	5,453
W5L	ANTIVIRALS, HIV-SPE	14	2	12	4	463
H7N	SMOKING DETERRENTS,	13	8	5	5	492
H7O	ANTIPSYCHOTICS,DOPA	13	3	10	163	5,842
C4M	HYPOGLYCEMICS, ALPH	12	0	12	3	471
H2M	ANTI-MANIA DRUGS	12	4	8	52	5,067
H7S	ANTIPSYCHOTICS,DOPA	11	3	8	2	232
F2A	DRUGS TO TREAT IMPO	10	2	8	0	129
J2D	ANTICHOLINERGICS/AN	10	4	6	20	2,134
Q5P	TOPICAL ANTI-INFLAM	10	3	7	152	12,833
V1B	ANTIMETABOLITES	10	4	6	20	1,567
Q3A	RECTAL PREPARATIONS	9	5	4	23	1,484
Q4F	VAGINAL ANTIFUNGALS	9	0	9	8	668
Z2F	MAST CELL STABILIZE	8	4	4	11	852
C6D	VITAMIN D PREPARATI	7	2	5	3	936
H7P	ANTIPSYCHOTICS,DOPA	7	3	4	21	1,603
J5H	ADRENERGIC VASOPRES	7	0	7	2	458
M9K	HEPARIN AND RELATED	7	4	3	3	2,290
N1D	PLATELET REDUCING A	7	0	7	0	165
Q6W	OPHTHALMIC ANTIBIOT	7	3	4	30	2,568
Q7A	NOSE PREPARATIONS,	7	7	0	5	472
V1E	STEROID ANTINEOPLAS	7	6	1	21	1,980
W2G	CHEMOTHERAPEUTICS,	7	2	5	2	593
W2F	NITROFURAN DERIVATI	6	0	6	23	2,646
W5M	ANTIVIRALS, HIV-SPE	6	2	4	3	304
J8A	ANOREXIC AGENTS	5	0	5	0	99
W1S	CARBAPENEMS (THIENA	5	0	5	1	141
D2A	FLUORIDE PREPARATIO	4	2	2	11	802
J9B	ANTISPASMODIC AGENT	4	0	4	1	44
Q3S	LAXATIVES, LOCAL/RE	4	3	1	106	9,277
Q8B	EAR PREPARATIONS, M	4	4	0	5	201
D5A	FAT ABSORPTION DECR	3	0	3	0	196
D9A	AMMONIA INHIBITORS	3	3	0	2	411
L0B	TOPICAL/MUCOUS MEMB	3	2	1	20	9,029
V1J	ANTIANDROGENIC AGEN	3	0	3	1	75
B0A	GENERAL INHALATION	2	1	1	12	585
C6E	VITAMIN E PREPARATI	2	0	2	13	2,322
M4A	BLOOD SUGAR DIAGNOS	2	1	1	0	1,744
Q3E	CHRONIC INFLAM. COL	2	0	2	0	108
Q4W	VAGINAL ANTIBIOTICS	2	0	2	0	147
Q5K	TOPICAL IMMUNOSUPPR	2	1	1	20	2,001
Q5R	TOPICAL ANTIPARASIT	2	1	1	9	1,591
Q6I	EYE ANTIBIOTIC-CORT	2	1	1	5	829
Q8F	OTIC PREPARATIONS,A	2	2	0	3	301

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ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: HIGH DOSE ALERT

REPORTING DATES: 03/23/03 - 09/30/03

	THERAPEUTIC CLASS CODE/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
U6A	PHARMACEUTICAL ADJU	2	2	0	1	203
V1F	ANTINEOPLASTICS,MIS	2	1	1	4	315
W1J	VANCOMYCIN AND DERI	2	0	2	8	547
W1Z	CEPHALOSPORINS - 4T	2	0	2	0	85
W4P	ANTILEPROTICS	2	0	2	0	105
X2B	SYRINGES AND ACCESS	2	2	0	0	944
C6H	PEDIATRIC VITAMIN P	1	0	1	19	1,595
C7D	METABOLIC DEFICIENC	1	0	1	0	338
H2X	TRICYCLIC ANTIDEPRE	1	1	0	10	323
H7R	ANTIPSYCH,DOPAMINE	1	0	1	4	115
L2A	EMOLLIENTS	1	1	0	25	2,325
L5A	KERATOLYTICS	1	0	1	15	1,087
N1B	HEMATINICS,OTHER	1	1	0	5	1,760
P1A	GROWTH HORMONES	1	1	0	6	197
Q6J	MYDRIATICS	1	1	0	9	414
Q6T	ARTIFICIAL TEARS	1	1	0	93	6,703
Q6U	OPHTHALMIC MAST CEL	1	1	0	5	345
Q6Y	EYE PREPARATIONS, M	1	0	1	6	1,099
Q8W	EAR PREPARATIONS,AN	1	1	0	1	644
U6N	VEHICLES	1	0	1	53	5,168
V1Q	ANTINEOPLASTIC SYST	1	0	1	0	111
W1F	AMINOGLYCOSIDES	1	1	0	6	640
W1O	OXAZOLIDINONES	1	0	1	1	283
W5I	ANTIVIRALS, HIV-SPE	1	0	1	0	220
W8E	ANTISEPTICS,GENERAL	1	1	0	0	283
HIGH	**DOSE ALERT TOTALS**	**78,547**	**24,036**	**54,511**	**114,489**	**2,789,531**

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ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: INGREDIENT DUPLICATION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H2S	SELECTIVE SEROTONIN	4,134	1,504	2,630	22,553	140,956
H7E	SEROTONIN-2 ANTAGON	2,445	939	1,506	2,601	34,885
H3A	ANALGESICS,NARCOTIC	2,297	461	1,836	33,394	288,588
H2U	TRICYCLIC ANTIDEPRE	1,599	641	958	3,704	32,985
J5D	BETA-ADRENERGIC AGE	1,564	1,028	536	1,267	85,428
H7C	SEROTONIN-NOREPINEP	1,229	302	927	7,002	35,959
H7B	ALPHA-2 RECEPTOR AN	1,204	417	787	2,866	25,004
P5A	GLUCOCORTICOIDS	975	516	459	431	37,172
H7D	NOREPINEPHRINE AND	708	311	397	2,508	25,233
J5G	BETA-ADRENERGICS AN	661	328	333	780	18,544
H3E	ANALGESIC/ANTIPYRET	632	267	365	1,118	51,212
H2F	ANTI-ANXIETY DRUGS	605	281	324	1,456	68,417
D6S	LAXATIVES AND CATHA	488	275	213	1,383	81,205
B3K	COUGH AND/OR COLD P	449	297	152	749	28,738
Z2A	ANTIHISTAMINES	432	244	188	858	75,650
H2E	SEDATIVE-HYPNOTICS,	422	203	219	608	19,205
Q3S	LAXATIVES, LOCAL/RE	420	124	296	106	9,277
H4B	ANTICONVULSANTS	373	268	105	6,093	227,543
C3B	IRON REPLACEMENT	343	167	176	151	17,198
Q7P	NASAL ANTI-INFLAMMA	340	206	134	337	16,351
H3F	ANTIMIGRAINE PREPAR	285	43	242	995	20,112
C6F	PRENATAL VITAMIN PR	275	184	91	402	15,350
D4K	GASTRIC ACID SECRET	185	166	19	929	98,008
C6M	FOLIC ACID PREPARAT	181	89	92	29	4,734
H6J	ANTIEMETIC/ANTIVERT	133	80	53	221	15,392
A1D	GENERAL BRONCHODILA	113	38	75	710	8,145
B3J	EXPECTORANTS	110	95	15	258	19,896
A4F	HYPOTENSIVES,ANGIOT	101	44	57	310	14,831
H7T	ANTIPSYCHOTICS,ATYP	100	9	91	3,217	147,456
C6B	VITAMIN B PREPARATI	99	46	53	24	2,712
A4Y	HYPOTENSIVES,MISCEL	86	15	71	102	2,062
R1L	POTASSIUM SPARING D	86	38	48	271	6,830
A4K	ACE INHIBITOR/CALCI	85	41	44	115	4,085
R1F	THIAZIDE AND RELATE	82	39	43	123	11,675
Q3D	HEMORRHOIDAL PREPAR	80	76	4	9	372
R1A	URINARY TRACT ANTIS	78	53	25	112	13,050
C6Z	MULTIVITAMIN PREPAR	72	26	46	117	20,036
S2B	NSAIDS, CYCLOOXYGEN	67	17	50	1,819	64,269
A4D	HYPOTENSIVES, ACE I	60	22	38	505	38,755
C1A	ELECTROLYTE DEPLETE	60	8	52	64	5,869
A9A	CALCIUM CHANNEL BLO	49	16	33	556	30,053
H2W	TRICYCLIC ANTIDEPRE	44	18	26	29	591
C4L	HYPOGLYCEMICS, BIGU	41	23	18	114	15,358
Q5P	TOPICAL ANTI-INFLAM	41	37	4	152	12,833
M4E	LIPOTROPICS	36	3	33	1,443	51,910
A7B	VASODILATORS,CORONA	35	11	24	1,482	25,537
R1M	LOOP DIURETICS	35	2	33	610	44,974

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C4K	HYPOGLYCEMICS, INSU	34	22	12	238	20,737
M9P	PLATELET AGGREGATIO	34	26	8	72	11,079
C4G	INSULINS	33	22	11	482	54,541
Q7A	NOSE PREPARATIONS,	33	21	12	5	472
J7C	BETA-ADRENERGIC BLO	31	13	18	360	31,578
Q5F	TOPICAL ANTIFUNGALS	31	26	5	219	16,198
W1A	PENICILLINS	31	2	29	396	15,089
C6G	GERIATRIC VITAMIN P	30	30	0	3	249
H7Y	TX FOR ATTENTION DE	30	30	0	166	8,138
C1F	CALCIUM REPLACEMENT	29	10	19	80	10,111
D4B	ANTACIDS	29	16	13	81	7,064
Q7E	NASAL ANTIHISTAMINE	28	23	5	39	1,157
Q9B	BENIGN PROSTATIC HY	28	15	13	34	3,020
Q3A	RECTAL PREPARATIONS	25	25	0	23	1,484
R1H	POTASSIUM SPARING D	25	13	12	47	4,741
H2V	TX FOR ATTENTION DE	22	17	5	438	19,746
H6H	SKELETAL MUSCLE REL	22	11	11	870	53,262
G1B	ESTROGEN/ANDROGEN C	20	17	3	5	805
C4N	HYPOGLYCEMICS, INSU	18	10	8	107	12,290
J2D	ANTICHOLINERGICS/AN	18	6	12	20	2,134
H6A	ANTIPARKINSONISM DR	17	15	2	213	16,231
H2G	ANTI-PSYCHOTICS,PHE	16	7	9	211	9,330
J2A	BELLADONNA ALKALOID	15	3	12	23	2,026
A1A	DIGITALIS GLYCOSIDE	14	8	6	184	14,505
G8A	CONTRACEPTIVES,ORAL	14	8	6	94	11,110
M9L	ORAL ANTICOAGULANTS	14	8	6	479	46,195
G1A	ESTROGENIC AGENTS	13	7	6	105	11,492
W2A	ABSORBABLE SULFONAM	12	2	10	205	5,453
C5J	IV SOLUTIONS: DEXTR	11	11	0	0	189
H2D	BARBITURATES	11	8	3	32	5,027
L5A	KERATOLYTICS	11	9	2	15	1,087
W5L	ANTIVIRALS, HIV-SPE	11	7	4	4	463
H7N	SMOKING DETERRENTS,	10	9	1	5	492
A4B	HYPOTENSIVES,SYMPAT	9	2	7	427	17,353
J7B	ALPHA-ADRENERGIC BL	9	6	3	57	3,081
Z4B	LEUKOTRIENE RECEPTO	9	4	5	61	10,301
D4F	ANTI-ULCER-H.PYLORI	8	6	2	6	358
Q3B	RECTAL/LOWER BOWEL	8	6	2	0	28
Q8F	OTIC PREPARATIONS,A	8	4	4	3	301
G8C	CONTRACEPTIVES,INJE	7	4	3	38	2,393
L2A	EMOLLIENTS	7	5	2	25	2,325
Q5B	TOPICAL PREPARATION	7	4	3	1	209
Q6I	EYE ANTIBIOTIC-CORT	7	5	2	5	829
Q6W	OPHTHALMIC ANTIBIOT	7	7	0	30	2,568
W1Q	QUINOLONES	7	3	4	62	11,576
W1W	CEPHALOSPORINS - 1S	7	0	7	19	5,897
W5G	HEPATITIS C TREATME	7	4	3	7	675

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A1B	XANTHINES	6	3	3	75	4,410
G8F	CONTRACEPTIVES,TRAN	6	4	2	50	6,931
J5B	ADRENERGICS, AROMAT	6	4	2	42	12,068
Q5H	TOPICAL LOCAL ANEST	6	4	2	60	2,010
D6F	DRUG TX-CHRONIC INF	5	3	2	16	1,670
P3A	THYROID HORMONES	5	4	1	156	27,590
Q6R	EYE ANTIHISTAMINES	5	4	1	28	2,087
H3D	ANALGESIC/ANTIPYRET	4	1	3	159	14,943
H6B	ANTIPARKINSONISM DR	4	1	3	37	6,385
L5H	ACNE AGENTS,TOPICAL	4	2	2	6	927
V1I	CHEMOTHERAPY RESCUE	4	4	0	1	166
A2A	ANTIARRHYTHMICS	3	1	2	21	2,559
G2A	PROGESTATIONAL AGEN	3	2	1	27	2,267
H2X	TRICYCLIC ANTIDEPRE	3	1	2	10	323
H6C	ANTITUSSIVES,NON-NA	3	1	2	24	2,180
H7P	ANTIPSYCHOTICS,DOPA	3	2	1	21	1,603
J7A	ALPHA/BETA-ADRENERG	3	1	2	38	4,005
J9A	INTESTINAL MOTILITY	3	0	3	575	15,264
Q5W	TOPICAL ANTIBIOTICS	3	3	0	59	7,983
Q6G	MIOTICS/OTHER INTRA	3	3	0	541	18,706
Q8W	EAR PREPARATIONS,AN	3	3	0	1	644
W1C	TETRACYCLINES	3	0	3	27	3,572
W2G	CHEMOTHERAPEUTICS,	3	2	1	2	593
W5C	ANTIVIRALS, HIV-SPE	3	3	0	7	830
C0D	ANTI-ALCOHOLIC PREP	2	1	1	0	89
C3M	MINERAL REPLACEMENT	2	1	1	0	18
C6C	VITAMIN C PREPARATI	2	1	1	6	2,437
C6E	VITAMIN E PREPARATI	2	1	1	13	2,322
C6H	PEDIATRIC VITAMIN P	2	2	0	19	1,595
C6L	VITAMIN B12 PREPARA	2	0	2	70	2,613
D4E	ANTI-ULCER PREPARAT	2	1	1	13	2,020
D4N	ANTIFLATULENTS	2	0	2	2	742
D6D	ANTIDIARRHEALS	2	2	0	84	6,485
J1B	CHOLINESTERASE INHI	2	1	1	59	7,612
J2B	ANTICHOLINERGICS,QU	2	2	0	11	1,008
J5E	SYMPATHOMIMETIC AGE	2	2	0	5	1,288
Q3E	CHRONIC INFLAM. COL	2	2	0	0	108
Q5R	TOPICAL ANTIPARASIT	2	1	1	9	1,591
Q5X	TOPICAL ANTIBIOTICS	2	2	0	0	65
Q6T	ARTIFICIAL TEARS	2	2	0	93	6,703
Q8B	EAR PREPARATIONS, M	2	2	0	5	201
W1D	MACROLIDES	2	0	2	26	5,837
W1J	VANCOMYCIN AND DERI	2	0	2	8	547
W1X	CEPHALOSPORINS - 2N	2	0	2	4	1,266
C1D	POTASSIUM REPLACEME	1	1	0	180	23,572
C5K	IV SOLUTIONS: DEXTR	1	1	0	0	121
C6D	VITAMIN D PREPARATI	1	1	0	3	936

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C6N	NIACIN PREPARATIONS	1	1	0	1	122
D4G	GASTRIC ENZYMES	1	1	0	0	272
D7L	BILE SALT SEQUESTRA	1	1	0	6	1,766
D8A	PANCREATIC ENZYMES	1	1	0	14	1,367
H7O	ANTIPSYCHOTICS,DOPA	1	0	1	163	5,842
J1A	PARASYMPATHETIC AGE	1	1	0	4	612
J3A	SMOKING DETERRENT A	1	1	0	31	2,428
L0B	TOPICAL/MUCOUS MEMB	1	1	0	20	9,029
L4A	ASTRINGENTS	1	1	0	0	2
M4G	HYPERGLYCEMICS	1	1	0	11	771
Q3H	HEMORRHOIDALS, LOCA	1	1	0	0	16
Q6P	EYE ANTIINFLAMMATOR	1	1	0	31	2,111
V1T	SELECTIVE ESTROGEN	1	1	0	6	764
W3A	ANTIFUNGAL ANTIBIOT	1	1	0	14	1,676
W5F	HEPATITIS B TREATME	1	1	0	0	39
W5J	ANTIVIRALS, HIV-SPE	1	0	1	69	3,040
INGREDIENT DUPLICATION TOTALS		**24,919**	**10,631**	**14,288**	**113,642**	**2,708,583**

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THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H4B	ANTICONVULSANTS	2,927	1,459	1,468	6,093	227,543
H6H	SKELETAL MUSCLE REL	1,377	722	655	870	53,262
H7T	ANTIPSYCHOTICS,ATYP	1,168	332	836	3,217	147,456
H3F	ANTIMIGRAINE PREPAR	922	767	155	995	20,112
J9A	INTESTINAL MOTILITY	442	202	240	575	15,264
R1M	LOOP DIURETICS	409	174	235	610	44,974
W1W	CEPHALOSPORINS - 1S	263	27	236	19	5,897
J7C	BETA-ADRENERGIC BLO	260	109	151	360	31,578
S2B	NSAIDS, CYCLOOXYGEN	227	139	88	1,819	64,269
C4L	HYPOGLYCEMICS, BIGU	224	136	88	114	15,358
W3B	ANTIFUNGAL AGENTS	223	186	37	54	7,288
R1F	THIAZIDE AND RELATE	221	108	113	123	11,675
H2S	SELECTIVE SEROTONIN	185	91	94	22,553	140,956
P5A	GLUCOCORTICOIDS	184	89	95	431	37,172
M4E	LIPOTROPICS	179	65	114	1,443	51,910
H6J	ANTIEMETIC/ANTIVERT	168	143	25	221	15,392
W1A	PENICILLINS	146	96	50	396	15,089
D4K	GASTRIC ACID SECRET	136	106	30	929	98,008
H7E	SEROTONIN-2 ANTAGON	131	71	60	2,601	34,885
A4B	HYPOTENSIVES,SYMPAT	129	78	51	427	17,353
H2E	SEDATIVE-HYPNOTICS,	129	69	60	608	19,205
H6A	ANTIPARKINSONISM DR	123	82	41	213	16,231
H2F	ANTI-ANXIETY DRUGS	122	68	54	1,456	68,417
W1D	MACROLIDES	111	84	27	26	5,837
M9L	ORAL ANTICOAGULANTS	110	80	30	479	46,195
H3A	ANALGESICS,NARCOTIC	96	39	57	33,394	288,588
A9A	CALCIUM CHANNEL BLO	88	43	45	556	30,053
H7D	NOREPINEPHRINE AND	86	51	35	2,508	25,233
Z2A	ANTIHISTAMINES	86	57	29	858	75,650
A4D	HYPOTENSIVES, ACE I	85	43	42	505	38,755
H2V	TX FOR ATTENTION DE	83	37	46	438	19,746
W5A	ANTIVIRALS, GENERAL	83	56	27	16	3,033
H7P	ANTIPSYCHOTICS,DOPA	82	40	42	21	1,603
C4K	HYPOGLYCEMICS, INSU	78	41	37	238	20,737
H2M	ANTI-MANIA DRUGS	78	49	29	52	5,067
P4L	BONE RESORPTION INH	78	21	57	214	18,280
R1A	URINARY TRACT ANTIS	78	58	20	112	13,050
W1Q	QUINOLONES	78	63	15	62	11,576
A7B	VASODILATORS,CORONA	74	27	47	1,482	25,537
H2D	BARBITURATES	74	39	35	32	5,027
J5D	BETA-ADRENERGIC AGE	74	63	11	1,267	85,428
D6S	LAXATIVES AND CATHA	73	67	6	1,383	81,205
G1A	ESTROGENIC AGENTS	73	32	41	105	11,492
A2A	ANTIARRHYTHMICS	72	35	37	21	2,559
C4N	HYPOGLYCEMICS, INSU	62	48	14	107	12,290
G8F	CONTRACEPTIVES,TRAN	62	19	43	50	6,931
R1H	POTASSIUM SPARING D	55	13	42	47	4,741

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C1D	POTASSIUM REPLACEME	53	32	21	180	23,572
H2U	TRICYCLIC ANTIDEPRE	47	33	14	3,704	32,985
Z2E	IMMUNOSUPPRESSIVES	47	34	13	83	8,647
W2A	ABSORBABLE SULFONAM	46	33	13	205	5,453
H0E	AGENTS TO TREAT MUL	44	40	4	12	2,018
R1L	POTASSIUM SPARING D	44	22	22	271	6,830
C6F	PRENATAL VITAMIN PR	42	26	16	402	15,350
H6B	ANTIPARKINSONISM DR	41	14	27	37	6,385
A1B	XANTHINES	40	27	13	75	4,410
H2G	ANTI-PSYCHOTICS,PHE	39	16	23	211	9,330
W2F	NITROFURAN DERIVATI	38	26	12	23	2,646
D4E	ANTI-ULCER PREPARAT	36	25	11	13	2,020
H7X	ANTIPSYCHOTICS, ATY	36	23	13	33	4,686
J7A	ALPHA/BETA-ADRENERG	35	18	17	38	4,005
A1A	DIGITALIS GLYCOSIDE	33	10	23	184	14,505
D7L	BILE SALT SEQUESTRA	33	30	3	6	1,766
J5H	ADRENERGIC VASOPRES	32	14	18	2	458
C1A	ELECTROLYTE DEPLETE	30	20	10	64	5,869
D6F	DRUG TX-CHRONIC INF	29	17	12	16	1,670
H7C	SEROTONIN-NOREPINEP	29	13	16	7,002	35,959
G2A	PROGESTATIONAL AGEN	27	17	10	27	2,267
H3D	ANALGESIC/ANTIPYRET	27	16	11	159	14,943
M9P	PLATELET AGGREGATIO	27	17	10	72	11,079
A1D	GENERAL BRONCHODILA	26	15	11	710	8,145
G8A	CONTRACEPTIVES,ORAL	26	16	10	94	11,110
C4G	INSULINS	25	13	12	482	54,541
W4E	ANAEROBIC ANTIPROTO	25	7	18	9	2,890
W2G	CHEMOTHERAPEUTICS,	24	15	9	2	593
A4F	HYPOTENSIVES,ANGIOT	23	18	5	310	14,831
B3J	EXPECTORANTS	21	18	3	258	19,896
H7O	ANTIPSYCHOTICS,DOPA	21	9	12	163	5,842
H7U	ANTIPSYCHOTICS, DOP	21	8	13	8	740
R1S	URINARY PH MODIFIER	21	10	11	5	689
C6D	VITAMIN D PREPARATI	20	13	7	3	936
G9B	CONTRACEPTIVES, INT	20	6	14	4	556
S2J	ANTI-INFLAMMATORY T	19	9	10	6	892
H7B	ALPHA-2 RECEPTOR AN	17	11	6	2,866	25,004
J5G	BETA-ADRENERGICS AN	17	11	6	780	18,544
A4A	HYPOTENSIVES,VASODI	16	6	10	36	2,081
D6E	IRRITABLE BOWEL SYN	15	11	4	5	1,227
W1C	TETRACYCLINES	15	7	8	27	3,572
W4A	ANTIMALARIAL DRUGS	15	11	4	32	3,105
H3E	ANALGESIC/ANTIPYRET	13	11	2	1,118	51,212
W3A	ANTIFUNGAL ANTIBIOT	13	8	5	14	1,676
D5A	FAT ABSORPTION DECR	12	12	0	0	196
W1F	AMINOGLYCOSIDES	12	9	3	6	640
W1K	LINCOSAMIDES	12	12	0	2	1,299

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THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H3T	NARCOTIC ANTAGONIST	11	4	7	0	753
P3A	THYROID HORMONES	11	7	4	156	27,590
W1X	CEPHALOSPORINS - 2N	11	7	4	4	1,266
J3A	SMOKING DETERRENT A	10	8	2	31	2,428
Z4B	LEUKOTRIENE RECEPTO	9	7	2	61	10,301
H2X	TRICYCLIC ANTIDEPRE	8	2	6	10	323
M9S	HEMORRHEOLOGIC AGEN	8	8	0	15	1,427
P3L	ANTITHYROID PREPARA	8	4	4	3	494
V1T	SELECTIVE ESTROGEN	8	7	1	6	764
C4M	HYPOGLYCEMICS, ALPH	7	6	1	3	471
G1B	ESTROGEN/ANDROGEN C	7	6	1	5	805
Q5S	TOPICAL SULFONAMIDE	7	4	3	5	1,892
R1E	CARBONIC ANHYDRASE	7	1	6	7	694
W5G	HEPATITIS C TREATME	7	0	7	7	675
C3B	IRON REPLACEMENT	6	3	3	151	17,198
D8A	PANCREATIC ENZYMES	6	5	1	14	1,367
C7A	HYPERURICEMIA TX -	5	1	4	16	2,535
J1A	PARASYMPATHETIC AGE	5	3	2	4	612
J7B	ALPHA-ADRENERGIC BL	5	5	0	57	3,081
A4Y	HYPOTENSIVES,MISCEL	4	0	4	102	2,062
C6M	FOLIC ACID PREPARAT	4	4	0	29	4,734
J1B	CHOLINESTERASE INHI	4	1	3	59	7,612
N1D	PLATELET REDUCING A	4	1	3	0	165
P5S	MINERALOCORTICOIDS	4	0	4	7	671
Q3A	RECTAL PREPARATIONS	4	4	0	23	1,484
Q3S	LAXATIVES, LOCAL/RE	4	4	0	106	9,277
Q5F	TOPICAL ANTIFUNGALS	4	4	0	219	16,198
Q6W	OPHTHALMIC ANTIBIOT	4	2	2	30	2,568
V1E	STEROID ANTINEOPLAS	4	4	0	21	1,980
V1Q	ANTINEOPLASTIC SYST	4	2	2	0	111
W5C	ANTIVIRALS, HIV-SPE	4	2	2	7	830
W5J	ANTIVIRALS, HIV-SPE	4	4	0	69	3,040
C1F	CALCIUM REPLACEMENT	3	3	0	80	10,111
H0A	LOCAL ANESTHETICS	3	3	0	4	591
J2B	ANTICHOLINERGICS,QU	3	3	0	11	1,008
Q7P	NASAL ANTI-INFLAMMA	3	3	0	337	16,351
R5B	URINARY TRACT ANALG	3	2	1	2	221
W1G	ANTITUBERCULAR ANTI	3	3	0	1	222
W1O	OXAZOLIDINONES	3	3	0	1	283
B3K	COUGH AND/OR COLD P	2	2	0	749	28,738
D2A	FLUORIDE PREPARATIO	2	2	0	11	802
D4B	ANTACIDS	2	2	0	81	7,064
D7A	BILE SALTS	2	0	2	5	705
L1A	ANTIPSORIATIC AGENT	2	2	0	0	29
L5H	ACNE AGENTS,TOPICAL	2	1	1	6	927
M4G	HYPERGLYCEMICS	2	2	0	11	771
P4B	BONE FORMATION STIM	2	2	0	0	109

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DRUG CONFLICT CODE: LOW DOSE ALERT

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE/NAME		TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
Q4F	VAGINAL ANTIFUNGALS	2	1	1	8	668
Q4K	VAGINAL ESTROGEN PR	2	2	0	17	922
V1B	ANTIMETABOLITES	2	1	1	20	1,567
W5L	ANTIVIRALS, HIV-SPE	2	1	1	4	463
W5M	ANTIVIRALS, HIV-SPE	2	2	0	3	304
C6H	PEDIATRIC VITAMIN P	1	1	0	19	1,595
C6L	VITAMIN B12 PREPARA	1	1	0	70	2,613
C6Z	MULTIVITAMIN PREPAR	1	1	0	117	20,036
D6D	ANTIDIARRHEALS	1	1	0	84	6,485
H2W	TRICYCLIC ANTIDEPRE	1	1	0	29	591
H7S	ANTIPSYCHOTICS,DOPA	1	0	1	2	232
H7Y	TX FOR ATTENTION DE	1	1	0	166	8,138
J2D	ANTICHOLINERGICS/AN	1	1	0	20	2,134
J5B	ADRENERGICS, AROMAT	1	1	0	42	12,068
J5F	ANAPHYLAXIS THERAPY	1	1	0	3	276
L9B	VITAMIN A DERIVATIV	1	1	0	5	1,093
M4A	BLOOD SUGAR DIAGNOS	1	1	0	0	1,744
Q4W	VAGINAL ANTIBIOTICS	1	1	0	0	147
Q5H	TOPICAL LOCAL ANEST	1	1	0	60	2,010
Q5K	TOPICAL IMMUNOSUPPR	1	1	0	20	2,001
Q6T	ARTIFICIAL TEARS	1	1	0	93	6,703
Q9B	BENIGN PROSTATIC HY	1	1	0	34	3,020
S2A	COLCHICINE	1	1	0	9	694
V1F	ANTINEOPLASTICS,MIS	1	0	1	4	315
W1Y	CEPHALOSPORINS - 3R	1	1	0	12	1,336
W4K	ANTIPROTOZOAL DRUGS	1	1	0	1	20
W4L	ANTHELMINTICS	1	1	0	0	76
W4P	ANTILEPROTICS	1	1	0	0	105
W5K	ANTIVIRALS, HIV-SPE	1	1	0	2	484
Y3A	DURABLE MEDICAL EQU	1	1	0	0	452
LOW DOSE ALERT TOTALS		**13,788**	**7,396**	**6,392**	**113,229**	**2,716,609**

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INDIANA MEDICAID PRESCRIPTION DRUG PROGRAM

ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: EXCESSIVE DURATION ALERT

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H2E	SEDATIVE-HYPNOTICS,	68	48	20	608	19,205
D4K	GASTRIC ACID SECRET	59	49	10	929	98,008
H3E	ANALGESIC/ANTIPYRET	56	41	15	1,118	51,212
H3A	ANALGESICS,NARCOTIC	47	8	39	33,394	288,588
D6D	ANTIDIARRHEALS	28	22	6	84	6,485
C6F	PRENATAL VITAMIN PR	26	19	7	402	15,350
H4B	ANTICONVULSANTS	22	10	12	6,093	227,543
W4A	ANTIMALARIAL DRUGS	21	13	8	32	3,105
D6S	LAXATIVES AND CATHA	20	11	9	1,383	81,205
H2F	ANTI-ANXIETY DRUGS	20	13	7	1,456	68,417
H7T	ANTIPSYCHOTICS,ATYP	19	6	13	3,217	147,456
C4G	INSULINS	14	8	6	482	54,541
W1D	MACROLIDES	12	10	2	26	5,837
W3B	ANTIFUNGAL AGENTS	12	11	1	54	7,288
A4D	HYPOTENSIVES, ACE I	11	4	7	505	38,755
J3A	SMOKING DETERRENT A	9	9	0	31	2,428
S2B	NSAIDS, CYCLOOXYGEN	9	2	7	1,819	64,269
C4L	HYPOGLYCEMICS, BIGU	8	4	4	114	15,358
H2S	SELECTIVE SEROTONIN	7	2	5	22,553	140,956
Q3A	RECTAL PREPARATIONS	7	7	0	23	1,484
W1Q	QUINOLONES	7	5	2	62	11,576
H2U	TRICYCLIC ANTIDEPRE	6	4	2	3,704	32,985
J7C	BETA-ADRENERGIC BLO	6	1	5	360	31,578
Q8W	EAR PREPARATIONS,AN	6	3	3	1	644
A9A	CALCIUM CHANNEL BLO	5	2	3	556	30,053
J5D	BETA-ADRENERGIC AGE	5	1	4	1,267	85,428
R1M	LOOP DIURETICS	5	0	5	610	44,974
W1C	TETRACYCLINES	5	2	3	27	3,572
H2V	TX FOR ATTENTION DE	4	2	2	438	19,746
C4K	HYPOGLYCEMICS, INSU	3	1	2	238	20,737
H2G	ANTI-PSYCHOTICS,PHE	3	1	2	211	9,330
H3F	ANTIMIGRAINE PREPAR	3	3	0	995	20,112
H6H	SKELETAL MUSCLE REL	3	1	2	870	53,262
P5A	GLUCOCORTICOIDS	3	3	0	431	37,172
Q5F	TOPICAL ANTIFUNGALS	3	1	2	219	16,198
W1A	PENICILLINS	3	1	2	396	15,089
W1W	CEPHALOSPORINS - 1S	3	1	2	19	5,897
A4F	HYPOTENSIVES,ANGIOT	2	2	0	310	14,831
A4K	ACE INHIBITOR/CALCI	2	1	1	115	4,085
A7B	VASODILATORS,CORONA	2	1	1	1,482	25,537
B3J	EXPECTORANTS	2	1	1	258	19,896
C4N	HYPOGLYCEMICS, INSU	2	1	1	107	12,290
D6F	DRUG TX-CHRONIC INF	2	0	2	16	1,670
G1A	ESTROGENIC AGENTS	2	1	1	105	11,492
G2A	PROGESTATIONAL AGEN	2	1	1	27	2,267
G8F	CONTRACEPTIVES,TRAN	2	0	2	50	6,931
H6A	ANTIPARKINSONISM DR	2	1	1	213	16,231

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INDIANA MEDICAID PRESCRIPTION DRUG PROGRAM

ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: EXCESSIVE DURATION ALERT

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE/NAME		TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H6J	ANTIEMETIC/ANTIVERT	2	1	1	221	15,392
H7N	SMOKING DETERRENTS,	2	2	0	5	492
J5B	ADRENERGICS, AROMAT	2	0	2	42	12,068
J5F	ANAPHYLAXIS THERAPY	2	1	1	3	276
J5G	BETA-ADRENERGICS AN	2	2	0	780	18,544
P2B	ANTIDIURETIC AND VA	2	1	1	25	2,372
P3A	THYROID HORMONES	2	1	1	156	27,590
R5A	URINARY TRACT ANEST	2	2	0	6	1,098
V1B	ANTIMETABOLITES	2	2	0	20	1,567
W1X	CEPHALOSPORINS - 2N	2	0	2	4	1,266
W2F	NITROFURAN DERIVATI	2	2	0	23	2,646
W5A	ANTIVIRALS, GENERAL	2	2	0	16	3,033
Z2A	ANTIHISTAMINES	2	1	1	858	75,650
B3K	COUGH AND/OR COLD P	1	0	1	749	28,738
C1A	ELECTROLYTE DEPLETE	1	0	1	64	5,869
C3B	IRON REPLACEMENT	1	0	1	151	17,198
C6K	VITAMIN K PREPARATI	1	1	0	2	120
D6E	IRRITABLE BOWEL SYN	1	1	0	5	1,227
H6C	ANTITUSSIVES,NON-NA	1	0	1	24	2,180
H7C	SEROTONIN-NOREPINEP	1	0	1	7,002	35,959
H7E	SEROTONIN-2 ANTAGON	1	0	1	2,601	34,885
H7X	ANTIPSYCHOTICS, ATY	1	1	0	33	4,686
J2B	ANTICHOLINERGICS,QU	1	1	0	11	1,008
L9B	VITAMIN A DERIVATIV	1	1	0	5	1,093
M9L	ORAL ANTICOAGULANTS	1	1	0	479	46,195
P0A	FERTILITY STIMULATI	1	0	1	0	27
P4L	BONE RESORPTION INH	1	1	0	214	18,280
P5S	MINERALOCORTICOIDS	1	1	0	7	671
Q6P	EYE ANTIINFLAMMATOR	1	0	1	31	2,111
Q6U	OPHTHALMIC MAST CEL	1	1	0	5	345
V1A	ALKYLATING AGENTS	1	0	1	0	331
Z2E	IMMUNOSUPPRESSIVES	1	0	1	83	8,647
EXCESSIVE DURATION ALERT TOTALS		**613**	**364**	**249**	**101,035**	**2,262,637**

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INDIANA MEDICAID PRESCRIPTION DRUG PROGRAM

ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: DRUG AGE PRECAUTION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE/NAME		TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H4B	ANTICONVULSANTS	1,372	1,107	265	6,093	227,543
B3K	COUGH AND/OR COLD P	1,367	556	811	749	28,738
A4B	HYPOTENSIVES,SYMPAT	928	268	660	427	17,353
Z2A	ANTIHISTAMINES	268	157	111	858	75,650
H3A	ANALGESICS,NARCOTIC	96	32	64	33,394	288,588
P1P	LHRH(GNRH)AGNST PIT	89	43	46	31	352
W1Q	QUINOLONES	74	13	61	62	11,576
H7T	ANTIPSYCHOTICS,ATYP	68	22	46	3,217	147,456
D4K	GASTRIC ACID SECRET	64	44	20	929	98,008
S2B	NSAIDS, CYCLOOXYGEN	58	19	39	1,819	64,269
W5J	ANTIVIRALS, HIV-SPE	56	50	6	69	3,040
B3J	EXPECTORANTS	46	10	36	258	19,896
A9A	CALCIUM CHANNEL BLO	31	14	17	556	30,053
A7B	VASODILATORS,CORONA	30	7	23	1,482	25,537
H2V	TX FOR ATTENTION DE	26	17	9	438	19,746
C4L	HYPOGLYCEMICS, BIGU	22	18	4	114	15,358
H2F	ANTI-ANXIETY DRUGS	22	17	5	1,456	68,417
H2S	SELECTIVE SEROTONIN	20	10	10	22,553	140,956
J5G	BETA-ADRENERGICS AN	20	14	6	780	18,544
H7D	NOREPINEPHRINE AND	18	11	7	2,508	25,233
H6H	SKELETAL MUSCLE REL	16	5	11	870	53,262
R1F	THIAZIDE AND RELATE	15	9	6	123	11,675
R1L	POTASSIUM SPARING D	13	7	6	271	6,830
A4D	HYPOTENSIVES, ACE I	12	5	7	505	38,755
H2U	TRICYCLIC ANTIDEPRE	12	4	8	3,704	32,985
C4K	HYPOGLYCEMICS, INSU	11	6	5	238	20,737
F1A	ANDROGENIC AGENTS	11	7	4	10	694
H7C	SEROTONIN-NOREPINEP	11	2	9	7,002	35,959
J5D	BETA-ADRENERGIC AGE	11	2	9	1,267	85,428
A4K	ACE INHIBITOR/CALCI	10	5	5	115	4,085
H7E	SEROTONIN-2 ANTAGON	10	9	1	2,601	34,885
P5A	GLUCOCORTICOIDS	10	9	1	431	37,172
H7Y	TX FOR ATTENTION DE	9	8	1	166	8,138
Z4B	LEUKOTRIENE RECEPTO	9	7	2	61	10,301
C6F	PRENATAL VITAMIN PR	8	4	4	402	15,350
H2E	SEDATIVE-HYPNOTICS,	7	6	1	608	19,205
A1A	DIGITALIS GLYCOSIDE	6	3	3	184	14,505
H7B	ALPHA-2 RECEPTOR AN	6	5	1	2,866	25,004
R1A	URINARY TRACT ANTIS	6	4	2	112	13,050
A4F	HYPOTENSIVES,ANGIOT	5	3	2	310	14,831
H6A	ANTIPARKINSONISM DR	5	5	0	213	16,231
V1O	ANTINEOPLASTIC LHRH	5	0	5	1	69
G8F	CONTRACEPTIVES,TRAN	4	2	2	50	6,931
H3F	ANTIMIGRAINE PREPAR	4	2	2	995	20,112
M9S	HEMORRHEOLOGIC AGEN	4	1	3	15	1,427
Q5K	TOPICAL IMMUNOSUPPR	4	4	0	20	2,001
Q7P	NASAL ANTI-INFLAMMA	4	2	2	337	16,351

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INDIANA MEDICAID PRESCRIPTION DRUG PROGRAM

ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: DRUG AGE PRECAUTION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
S2J	ANTI-INFLAMMATORY T	4	2	2	6	892
V1B	ANTIMETABOLITES	4	2	2	20	1,567
G1A	ESTROGENIC AGENTS	3	3	0	105	11,492
H6J	ANTIEMETIC/ANTIVERT	3	2	1	221	15,392
J7C	BETA-ADRENERGIC BLO	3	0	3	360	31,578
M9P	PLATELET AGGREGATIO	3	3	0	72	11,079
P4L	BONE RESORPTION INH	3	0	3	214	18,280
W2F	NITROFURAN DERIVATI	3	3	0	23	2,646
A4Y	HYPOTENSIVES,MISCEL	2	1	1	102	2,062
C3B	IRON REPLACEMENT	2	0	2	151	17,198
C4G	INSULINS	2	0	2	482	54,541
C4N	HYPOGLYCEMICS, INSU	2	2	0	107	12,290
G8A	CONTRACEPTIVES,ORAL	2	2	0	94	11,110
H2M	ANTI-MANIA DRUGS	2	2	0	52	5,067
H3E	ANALGESIC/ANTIPYRET	2	1	1	1,118	51,212
P3A	THYROID HORMONES	2	2	0	156	27,590
Q5F	TOPICAL ANTIFUNGALS	2	0	2	219	16,198
Q5P	TOPICAL ANTI-INFLAM	2	1	1	152	12,833
Q5W	TOPICAL ANTIBIOTICS	2	2	0	59	7,983
W1A	PENICILLINS	2	0	2	396	15,089
W2A	ABSORBABLE SULFONAM	2	0	2	205	5,453
C1D	POTASSIUM REPLACEME	1	0	1	180	23,572
D6F	DRUG TX-CHRONIC INF	1	0	1	16	1,670
D6S	LAXATIVES AND CATHA	1	1	0	1,383	81,205
H2D	BARBITURATES	1	1	0	32	5,027
H3D	ANALGESIC/ANTIPYRET	1	1	0	159	14,943
H7N	SMOKING DETERRENTS,	1	1	0	5	492
H7X	ANTIPSYCHOTICS, ATY	1	0	1	33	4,686
J2A	BELLADONNA ALKALOID	1	1	0	23	2,026
J2D	ANTICHOLINERGICS/AN	1	0	1	20	2,134
L9B	VITAMIN A DERIVATIV	1	0	1	5	1,093
M4E	LIPOTROPICS	1	0	1	1,443	51,910
M9L	ORAL ANTICOAGULANTS	1	0	1	479	46,195
P2B	ANTIDIURETIC AND VA	1	1	0	25	2,372
Q5V	TOPICAL ANTIVIRALS	1	1	0	6	581
Q6G	MIOTICS/OTHER INTRA	1	1	0	541	18,706
R1M	LOOP DIURETICS	1	0	1	610	44,974
W1C	TETRACYCLINES	1	0	1	27	3,572
W1F	AMINOGLYCOSIDES	1	1	0	6	640
W1W	CEPHALOSPORINS - 1S	1	0	1	19	5,897
W3A	ANTIFUNGAL ANTIBIOT	1	0	1	14	1,676
Z2G	IMMUNOMODULATORS	1	0	1	12	2,002
DRUG-AGE PRECAUTION TOTALS		**4,976**	**2,592**	**2,384**	**110,622**	**2,519,211**

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INDIANA MEDICAID PRESCRIPTION DRUG PROGRAM

ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: DRUG GENDER ALERT

REPORTING DATES: 03/23/03 - 09/30/03

	THERAPEUTIC CLASS CODE/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
G8C	CONTRACEPTIVES,INJE	69	41	28	38	2,393
C6F	PRENATAL VITAMIN PR	34	23	11	402	15,350
G1A	ESTROGENIC AGENTS	18	11	7	105	11,492
H4B	ANTICONVULSANTS	8	8	0	6,093	227,543
V1F	ANTINEOPLASTICS,MIS	8	2	6	4	315
G8A	CONTRACEPTIVES,ORAL	6	6	0	94	11,110
H6H	SKELETAL MUSCLE REL	3	0	3	870	53,262
H7T	ANTIPSYCHOTICS,ATYP	3	1	2	3,217	147,456
C3B	IRON REPLACEMENT	2	2	0	151	17,198
Q9B	BENIGN PROSTATIC HY	2	2	0	34	3,020
A4A	HYPOTENSIVES,VASODI	1	1	0	36	2,081
A4D	HYPOTENSIVES, ACE I	1	0	1	505	38,755
B3K	COUGH AND/OR COLD P	1	1	0	749	28,738
F1A	ANDROGENIC AGENTS	1	1	0	10	694
H2S	SELECTIVE SEROTONIN	1	0	1	22,553	140,956
H3A	ANALGESICS,NARCOTIC	1	0	1	33,394	288,588
H3F	ANTIMIGRAINE PREPAR	1	0	1	995	20,112
H6B	ANTIPARKINSONISM DR	1	0	1	37	6,385
J3A	SMOKING DETERRENT A	1	1	0	31	2,428
Q4F	VAGINAL ANTIFUNGALS	1	1	0	8	668
W1W	CEPHALOSPORINS - 1S	1	0	1	19	5,897
DRUG-GENDER ALERT TOTALS		**164**	**101**	**63**	**69,345**	**1,024,441**

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INDIANA MEDICAID PRESCRIPTION DRUG PROGRAM

ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: THERAPEUTIC DUPLICATION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
H3A	ANALGESICS,NARCOTIC	50,564	40,496	10,068	33,394	288,588
H2S	SELECTIVE SEROTONIN	24,967	23,832	1,135	22,553	140,956
H4B	ANTICONVULSANTS	18,996	7,379	11,617	6,093	227,543
H7T	ANTIPSYCHOTICS,ATYP	15,170	5,827	9,343	3,217	147,456
M9L	ORAL ANTICOAGULANTS	11,881	3,241	8,640	479	46,195
H7C	SEROTONIN-NOREPINEP	6,279	6,060	219	7,002	35,959
D6S	LAXATIVES AND CATHA	4,721	2,122	2,599	1,383	81,205
H2U	TRICYCLIC ANTIDEPRE	4,337	4,143	194	3,704	32,985
M4E	LIPOTROPICS	4,157	2,156	2,001	1,443	51,910
R1M	LOOP DIURETICS	3,593	1,503	2,090	610	44,974
D4K	GASTRIC ACID SECRET	3,545	2,819	726	929	98,008
J5D	BETA-ADRENERGIC AGE	3,415	2,143	1,272	1,267	85,428
H7E	SEROTONIN-2 ANTAGON	3,219	3,102	117	2,601	34,885
S2B	NSAIDS, CYCLOOXYGEN	3,125	1,932	1,193	1,819	64,269
H2F	ANTI-ANXIETY DRUGS	3,031	1,466	1,565	1,456	68,417
H6H	SKELETAL MUSCLE REL	2,903	1,289	1,614	870	53,262
H7B	ALPHA-2 RECEPTOR AN	2,844	2,736	108	2,866	25,004
C4G	INSULINS	2,806	1,319	1,487	482	54,541
A7B	VASODILATORS,CORONA	2,762	1,641	1,121	1,482	25,537
H7D	NOREPINEPHRINE AND	1,945	1,831	114	2,508	25,233
A4D	HYPOTENSIVES, ACE I	1,827	946	881	505	38,755
Z2A	ANTIHISTAMINES	1,675	966	709	858	75,650
P5A	GLUCOCORTICOIDS	1,302	700	602	431	37,172
H3F	ANTIMIGRAINE PREPAR	1,232	1,149	83	995	20,112
J7C	BETA-ADRENERGIC BLO	1,186	471	715	360	31,578
H6A	ANTIPARKINSONISM DR	1,172	589	583	213	16,231
A9A	CALCIUM CHANNEL BLO	1,043	494	549	556	30,053
H2V	TX FOR ATTENTION DE	1,015	486	529	438	19,746
J5B	ADRENERGICS, AROMAT	929	439	490	42	12,068
P3A	THYROID HORMONES	922	333	589	156	27,590
A4F	HYPOTENSIVES,ANGIOT	818	601	217	310	14,831
C4K	HYPOGLYCEMICS, INSU	815	373	442	238	20,737
W1A	PENICILLINS	807	563	244	396	15,089
H2G	ANTI-PSYCHOTICS,PHE	798	358	440	211	9,330
Q6G	MIOTICS/OTHER INTRA	731	432	299	541	18,706
H3E	ANALGESIC/ANTIPYRET	712	618	94	1,118	51,212
A1A	DIGITALIS GLYCOSIDE	578	294	284	184	14,505
A1D	GENERAL BRONCHODILA	565	516	49	710	8,145
H2E	SEDATIVE-HYPNOTICS,	519	345	174	608	19,205
Z2E	IMMUNOSUPPRESSIVES	510	293	217	83	8,647
A4B	HYPOTENSIVES,SYMPAT	457	166	291	427	17,353
H7O	ANTIPSYCHOTICS,DOPA	436	241	195	163	5,842
C1D	POTASSIUM REPLACEME	432	156	276	180	23,572
C6Z	MULTIVITAMIN PREPAR	377	134	243	117	20,036
H7Y	TX FOR ATTENTION DE	367	341	26	166	8,138
R1A	URINARY TRACT ANTIS	320	305	15	112	13,050
R1F	THIAZIDE AND RELATE	320	122	198	123	11,675

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INDIANA MEDICAID PRESCRIPTION DRUG PROGRAM

ACS PROSPECTIVE DUR REPORT

DRUG CONFLICT CODE: THERAPEUTIC DUPLICATION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
A4K	ACE INHIBITOR/CALCI	316	286	30	115	4,085
H3D	ANALGESIC/ANTIPYRET	310	141	169	159	14,943
R1L	POTASSIUM SPARING D	304	263	41	271	6,830
B3J	EXPECTORANTS	292	206	86	258	19,896
W2A	ABSORBABLE SULFONAM	290	250	40	205	5,453
Q5F	TOPICAL ANTIFUNGALS	253	235	18	219	16,198
C3B	IRON REPLACEMENT	252	152	100	151	17,198
C4L	HYPOGLYCEMICS, BIGU	250	102	148	114	15,358
B3K	COUGH AND/OR COLD P	245	234	11	749	28,738
P4L	BONE RESORPTION INH	244	125	119	214	18,280
C6F	PRENATAL VITAMIN PR	213	192	21	402	15,350
H2D	BARBITURATES	212	70	142	32	5,027
Q5P	TOPICAL ANTI-INFLAM	202	191	11	152	12,833
A4A	HYPOTENSIVES,VASODI	197	79	118	36	2,081
J1B	CHOLINESTERASE INHI	197	41	156	59	7,612
W1Q	QUINOLONES	192	35	157	62	11,576
C4N	HYPOGLYCEMICS, INSU	183	106	77	107	12,290
C1A	ELECTROLYTE DEPLETE	173	64	109	64	5,869
H6B	ANTIPARKINSONISM DR	167	67	100	37	6,385
H6J	ANTIEMETIC/ANTIVERT	159	122	37	221	15,392
A4Y	HYPOTENSIVES,MISCEL	157	152	5	102	2,062
M9P	PLATELET AGGREGATIO	157	72	85	72	11,079
W5J	ANTIVIRALS, HIV-SPE	151	63	88	69	3,040
G1A	ESTROGENIC AGENTS	144	63	81	105	11,492
Q9B	BENIGN PROSTATIC HY	144	72	72	34	3,020
H7X	ANTIPSYCHOTICS, ATY	141	51	90	33	4,686
J7B	ALPHA-ADRENERGIC BL	123	68	55	57	3,081
H7P	ANTIPSYCHOTICS,DOPA	113	45	68	21	1,603
R1H	POTASSIUM SPARING D	100	56	44	47	4,741
H2M	ANTI-MANIA DRUGS	99	49	50	52	5,067
J5G	BETA-ADRENERGICS AN	98	87	11	780	18,544
A2A	ANTIARRHYTHMICS	90	20	70	21	2,559
J7A	ALPHA/BETA-ADRENERG	82	39	43	38	4,005
W8F	IRRIGANTS	79	52	27	16	4,804
G8A	CONTRACEPTIVES,ORAL	78	41	37	94	11,110
J3A	SMOKING DETERRENT A	78	54	24	31	2,428
W1D	MACROLIDES	73	22	51	26	5,837
Q6W	OPHTHALMIC ANTIBIOT	68	65	3	30	2,568
Q5W	TOPICAL ANTIBIOTICS	67	59	8	59	7,983
Q7P	NASAL ANTI-INFLAMMA	66	60	6	337	16,351
W1W	CEPHALOSPORINS - 1S	66	10	56	19	5,897
C1F	CALCIUM REPLACEMENT	62	48	14	80	10,111
Q3A	RECTAL PREPARATIONS	58	57	1	23	1,484
W1C	TETRACYCLINES	58	13	45	27	3,572
Q5H	TOPICAL LOCAL ANEST	53	51	2	60	2,010
J9A	INTESTINAL MOTILITY	50	22	28	575	15,264
A1B	XANTHINES	49	22	27	75	4,410

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INDIANA MEDICAID PRESCRIPTION DRUG PROGRAM

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REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
Q6T	ARTIFICIAL TEARS	49	46	3	93	6,703
Q6P	EYE ANTIINFLAMMATOR	47	23	24	31	2,111
W3B	ANTIFUNGAL AGENTS	42	22	20	54	7,288
D6D	ANTIDIARRHEALS	40	22	18	84	6,485
H7U	ANTIPSYCHOTICS, DOP	39	15	24	8	740
Q3S	LAXATIVES, LOCAL/RE	38	37	1	106	9,277
L0B	TOPICAL/MUCOUS MEMB	37	33	4	20	9,029
R1E	CARBONIC ANHYDRASE	32	14	18	7	694
V1B	ANTIMETABOLITES	32	17	15	20	1,567
D4E	ANTI-ULCER PREPARAT	30	24	6	13	2,020
W4A	ANTIMALARIAL DRUGS	29	14	15	32	3,105
G8C	CONTRACEPTIVES,INJE	28	23	5	38	2,393
W2F	NITROFURAN DERIVATI	28	10	18	23	2,646
D4B	ANTACIDS	27	22	5	81	7,064
G8F	CONTRACEPTIVES,TRAN	27	11	16	50	6,931
C6C	VITAMIN C PREPARATI	24	0	24	6	2,437
H2W	TRICYCLIC ANTIDEPRE	24	23	1	29	591
P2B	ANTIDIURETIC AND VA	24	15	9	25	2,372
C7A	HYPERURICEMIA TX -	23	11	12	16	2,535
G2A	PROGESTATIONAL AGEN	23	11	12	27	2,267
W1Y	CEPHALOSPORINS - 3R	23	12	11	12	1,336
D7L	BILE SALT SEQUESTRA	22	22	0	6	1,766
W5A	ANTIVIRALS, GENERAL	21	14	7	16	3,033
Q5R	TOPICAL ANTIPARASIT	19	17	2	9	1,591
F1A	ANDROGENIC AGENTS	18	13	5	10	694
N1B	HEMATINICS,OTHER	17	11	6	5	1,760
W4E	ANAEROBIC ANTIPROTO	16	3	13	9	2,890
W5K	ANTIVIRALS, HIV-SPE	16	8	8	2	484
Z4B	LEUKOTRIENE RECEPTO	16	6	10	61	10,301
C6M	FOLIC ACID PREPARAT	15	5	10	29	4,734
D8A	PANCREATIC ENZYMES	15	14	1	14	1,367
M9K	HEPARIN AND RELATED	15	3	12	3	2,290
C6H	PEDIATRIC VITAMIN P	14	10	4	19	1,595
W5C	ANTIVIRALS, HIV-SPE	13	10	3	7	830
C6B	VITAMIN B PREPARATI	12	11	1	24	2,712
H7N	SMOKING DETERRENTS,	12	12	0	5	492
Q7E	NASAL ANTIHISTAMINE	12	12	0	39	1,157
W2E	ANTI-MYCOBACTERIUM	11	6	5	5	265
C6L	VITAMIN B12 PREPARA	10	9	1	70	2,613
H6C	ANTITUSSIVES,NON-NA	10	7	3	24	2,180
D6F	DRUG TX-CHRONIC INF	9	2	7	16	1,670
M9S	HEMORRHEOLOGIC AGEN	9	2	7	15	1,427
W3A	ANTIFUNGAL ANTIBIOT	9	6	3	14	1,676
H7S	ANTIPSYCHOTICS,DOPA	8	4	4	2	232
J2A	BELLADONNA ALKALOID	8	5	3	23	2,026
M4A	BLOOD SUGAR DIAGNOS	8	6	2	0	1,744
M4G	HYPERGLYCEMICS	8	8	0	11	771

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DRUG CONFLICT CODE: THERAPEUTIC DUPLICATION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE	/NAME	TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
S2I	ANTI-INFLAMMATORY,	8	3	5	4	265
D4F	ANTI-ULCER-H.PYLORI	7	7	0	6	358
G1B	ESTROGEN/ANDROGEN C	7	6	1	5	805
L9B	VITAMIN A DERIVATIV	7	7	0	5	1,093
W1X	CEPHALOSPORINS - 2N	7	0	7	4	1,266
J2B	ANTICHOLINERGICS,QU	6	4	2	11	1,008
L2A	EMOLLIENTS	6	6	0	25	2,325
Q6I	EYE ANTIBIOTIC-CORT	6	6	0	5	829
D6E	IRRITABLE BOWEL SYN	5	3	2	5	1,227
H0E	AGENTS TO TREAT MUL	5	5	0	12	2,018
H2X	TRICYCLIC ANTIDEPRE	5	4	1	10	323
P3L	ANTITHYROID PREPARA	5	3	2	3	494
Q6R	EYE ANTIHISTAMINES	5	5	0	28	2,087
Q8W	EAR PREPARATIONS,AN	5	4	1	1	644
S2A	COLCHICINE	5	3	2	9	694
V1E	STEROID ANTINEOPLAS	5	1	4	21	1,980
W1J	VANCOMYCIN AND DERI	5	5	0	8	547
W1K	LINCOSAMIDES	5	0	5	2	1,299
W2G	CHEMOTHERAPEUTICS,	5	5	0	2	593
Z2F	MAST CELL STABILIZE	5	4	1	11	852
C1H	MAGNESIUM SALTS REP	4	0	4	7	889
C6E	VITAMIN E PREPARATI	4	3	1	13	2,322
C6G	GERIATRIC VITAMIN P	4	4	0	3	249
D2A	FLUORIDE PREPARATIO	4	3	1	11	802
D4N	ANTIFLATULENTS	4	4	0	2	742
J5E	SYMPATHOMIMETIC AGE	4	2	2	5	1,288
Q6U	OPHTHALMIC MAST CEL	4	4	0	5	345
R5B	URINARY TRACT ANALG	4	1	3	2	221
U6N	VEHICLES	4	4	0	53	5,168
W5G	HEPATITIS C TREATME	4	3	1	7	675
B0A	GENERAL INHALATION	3	1	2	12	585
C1B	SODIUM/SALINE PREPA	3	2	1	1	2,176
C5B	PROTEIN REPLACEMENT	3	3	0	0	304
C6D	VITAMIN D PREPARATI	3	3	0	3	936
H2A	CENTRAL NERVOUS SYS	3	1	2	13	210
H3T	NARCOTIC ANTAGONIST	3	0	3	0	753
J2D	ANTICHOLINERGICS/AN	3	1	2	20	2,134
L5A	KERATOLYTICS	3	2	1	15	1,087
L5F	ANTIPSORIATICS AGEN	3	2	1	15	690
L5G	ROSACEA AGENTS, TOP	3	3	0	4	502
P1A	GROWTH HORMONES	3	2	1	6	197
Q4F	VAGINAL ANTIFUNGALS	3	3	0	8	668
Q5V	TOPICAL ANTIVIRALS	3	3	0	6	581
Q8F	OTIC PREPARATIONS,A	3	2	1	3	301
W1G	ANTITUBERCULAR ANTI	3	0	3	1	222
C4M	HYPOGLYCEMICS, ALPH	2	1	1	3	471
C5J	IV SOLUTIONS: DEXTR	2	2	0	0	189

DRUG CONFLICT CODE: THERAPEUTIC DUPLICATION

REPORTING DATES: 03/23/03 - 09/30/03

THERAPEUTIC CLASS CODE/NAME		TOTAL MESSAGES	PAID MESSAGES	DENIAL MESSAGES	OVERRIDDEN CLAIMS	TOTAL CLAIMS
C7D	METABOLIC DEFICIENC	2	0	2	0	338
D7A	BILE SALTS	2	1	1	5	705
H7J	MAOIS - NON-SELECTI	2	2	0	0	73
J1A	PARASYMPATHETIC AGE	2	0	2	4	612
L5H	ACNE AGENTS,TOPICAL	2	2	0	6	927
N1C	LEUKOCYTE (WBC) STI	2	2	0	0	91
P1P	LHRH(GNRH)AGNST PIT	2	1	1	31	352
Q4K	VAGINAL ESTROGEN PR	2	1	1	17	922
Q5K	TOPICAL IMMUNOSUPPR	2	2	0	20	2,001
Q6S	EYE SULFONAMIDES	2	2	0	1	227
Q7A	NOSE PREPARATIONS,	2	0	2	5	472
R5A	URINARY TRACT ANEST	2	0	2	6	1,098
S2J	ANTI-INFLAMMATORY T	2	0	2	6	892
U6A	PHARMACEUTICAL ADJU	2	1	1	1	203
V1F	ANTINEOPLASTICS,MIS	2	1	1	4	315
W4P	ANTILEPROTICS	2	1	1	0	105
W5D	ANTIVIRAL MONOCLONA	2	1	1	0	148
W7K	ANTISERA	2	2	0	0	50
X2B	SYRINGES AND ACCESS	2	2	0	0	944
Z2G	IMMUNOMODULATORS	2	1	1	12	2,002
C6N	NIACIN PREPARATIONS	1	1	0	1	122
C6T	VITAMIN B1 PREPARAT	1	0	1	3	507
H6I	AMYOTROPHIC LATERAL	1	0	1	0	24
J5H	ADRENERGIC VASOPRES	1	1	0	2	458
L1B	ACNE AGENTS,SYSTEMI	1	1	0	1	101
L9C	HYPOPIGMENTATION AG	1	1	0	0	72
N1D	PLATELET REDUCING A	1	0	1	0	165
P1M	LHRH(GNRH) AGONIST	1	0	1	1	151
P5S	MINERALOCORTICOIDS	1	0	1	7	671
Q6D	EYE VASOCONSTRICTOR	1	1	0	0	10
Q6Y	EYE PREPARATIONS, M	1	1	0	6	1,099
R4A	KIDNEY STONE AGENTS	1	0	1	0	32
V1A	ALKYLATING AGENTS	1	1	0	0	331
W1F	AMINOGLYCOSIDES	1	1	0	6	640
W1S	CARBAPENEMS (THIENA	1	1	0	1	141
W1Z	CEPHALOSPORINS - 4T	1	0	1	0	85
X3A	OSTOMY SUPPLIES	1	1	0	0	107
THERAPEUTIC DUPLICATION TOTALS		**204,549**	**134,645**	**69,904**	**114,663**	**2,826,083**

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 2.2 ProDUR HARD EDITS

ATTACHMENT 2.2.A ProDUR Hard Edits: REGULAR PA ACTIVITY

Regular PA Program Activity
Contractor: Health Care Excel (HCE)
Reporting Period: 10/1/02 to 9/30/2003

FFY 2003	Early Refill	High Dose	Drug-Drug	Therapeutic Duplication	34 Day Supply	Totals
Program Start Date	7/1/2002	3/28/2003	1/15/2003	7/22/2003	7/1/2002	
October						
Approved	6,933	0	0	0	3	6,936
Denied	48	0	0	0	0	48
Suspended	5	0	0	0	0	5
MTD	6,986	0	0	0	3	6,989
Cumulative FFYTD	6,986	0	0	0	3	6,989
November						
Approved	5,590	0	0	0	8	5,598
Denied	349	0	0	0	1	350
Suspended	85	0	0	0	0	85
MTD	6,024	0	0	0	9	6,033
Cumulative FFYTD	13,010	0	0	0	12	13,022
December						
Approved	6,003	0	0	0	5	6,008
Denied	113	0	0	0	0	113
Suspended	69	0	0	0	0	69
MTD	6,185	0	0	0	5	6,190
Cumulative FFYTD	19,195	0	0	0	17	19,212
January						
Approved	5,758	0	156	0	3	5,917
Denied	171	0	0	0	0	171
Suspended	48	0	102	0	0	150
MTD	5,977	0	258	0	3	6,238
Cumulative FFYTD	25,172	0	258	0	20	25,450
February						
Approved	4,889	0	218	0	1	5,108
Denied	163	0	2	0	0	165
Suspended	81	0	85	0	0	166
MTD	5,133	0	305	0	1	5,439
Cumulative FFYTD	30,305	0	563	0	21	30,889
March						
Approved	5,327	3,211	179	0	24	8,741
Denied	230	309	6	0	2	547
Suspended	122	21	67	0	0	210
MTD	5,679	3,541	252	0	26	9,498
Cumulative FFYTD	35,984	3,541	815	0	47	40,387
April						
Approved	7,054	3,707	247	0	10	11,018
Denied	136	127	1	0	0	264
Suspended	25	5	42	0	0	72
MTD	7,215	3,839	290	0	10	11,354
Cumulative FFYTD	43,199	7,380	1,105	0	57	51,741

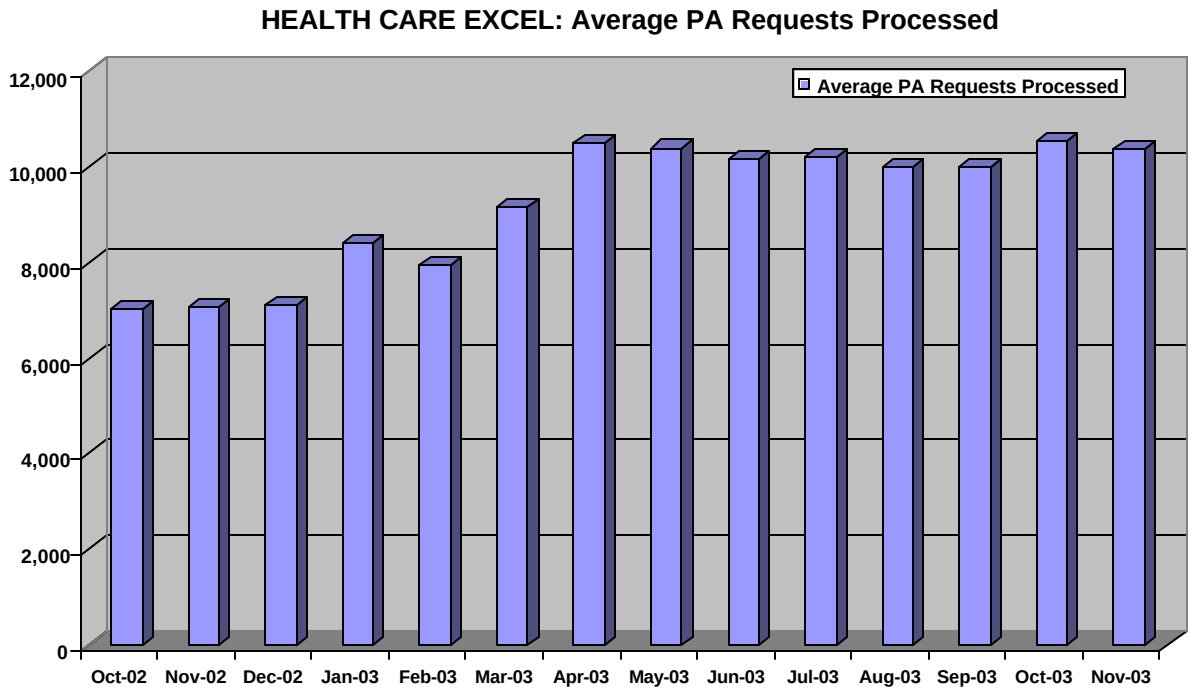
ATTACHMENT 2.2.A --continued--

ProDUR Hard Edits : Regular PA Activity

Regular PA Program Activity – continued --

FFY 2003	Early Refill	High Dose	Drug-Drug	Therapeutic Duplication	34 Day Supply	Totals
May						
Approved	5,747	1,269	126	0	16	7,158
Denied	285	177	0	0	0	462
Suspended	52	12	24	0	0	88
MTD	6,084	1,458	150	0	16	7,708
Cumulative FFYTD	49,283	8,838	1,255	0	73	59,449
June						
Approved	5,687	951	137	0	19	6,794
Denied	288	133	2	0	1	424
Suspended	22	6	2	0	0	30
MTD	5,997	1,090	141	0	20	7,248
Cumulative FFYTD	55,280	9,928	1,396	0	93	66,697
July						
Approved	7,297	847	175	154	5	8,478
Denied	414	115	0	1	0	530
Suspended	40	1	12	4	0	57
MTD	7,751	963	187	159	5	9,065
Cumulative FFYTD	63,031	10,891	1,583	159	98	75,762
August						
Approved	5,193	580	138	444	7	6,362
Denied	240	69	2	6	1	318
Suspended	27	3	8	19	0	57
MTD	5,460	652	148	469	8	6,737
Cumulative FFYTD	68,491	11,543	1,731	628	106	82,499
September						
Approved	5,709	609	274	1,880	5	8,477
Denied	224	62	0	7	1	294
Suspended	66	4	26	165	1	262
MTD	5,999	675	300	2,052	7	9,033
Cumulative FFYTD	74,490	12,218	2,031	2,680	113	91,532

ATTACHMENT 2.2.A --continued-- ProDUR Hard Edits: Regular PA Activity



ATTACHMENT 2.2.B ProDUR Hard Edits: IRDP Prior Authorization Activity

IRDP PA ACTIVITY*

Contractor: HCE (Reporting Dates: 10/1/02 to 9/30/03) *IRDP Program was phased-out as the PDL Program was phased-in

FFY 2003	Trama-dol	COX-2/ Brand NSAIDs	Brand Salicylate	PPI	H2 Antagonist	Carafate	Cytotec	Growth Hormone	Stadol	BMN	Azithro-mycin	Lactu-lose	Oxy-codone	Oxycontin	Synagis	T-Retinoin	Hydrocodone /APAP Oxycodone /APAP	Duragesic	No PA Required	Totals
Program Start Date	1/7/2002	1/7/2002	1/7/2002	1/7/2002	1/7/2002	1/7/2002	1/7/2002	1/7/2002	1/7/2002	9/4/2001	4/15/2002	4/15/2002	4/15/2002	4/15/2002	4/15/2002	4/15/2002	7/22/2002	7/22/2002		
October																				
Approved	205	465	0	395	165	1	7	4	10	86	27	39	16	39	278	19	15	98	0	1869
Denied	31	25	0	41	5	3	1	2	11	123	0	8	2	4	13	0	14	6	0	289
Suspended	55	160	0	6	22	0	2	9	2	18	1	5	2	3	70	1	3	9	190	558
MTD	291	650	0	442	192	4	10	15	23	227	28	52	20	46	361	20	32	113	190	2716
FFYTD	291	650	0	442	192	4	10	15	23	227	28	52	20	46	361	20	32	113	190	2716
November																				
Approved	125	329	0	0	103	0	4	7	6	38	24	30	15	32	131	28	12	103	0	987
Denied	25	27	0	0	6	2	0	3	2	58	4	3	2	15	12	0	11	6	0	176
Suspended	59	138	0	0	21	1	0	4	3	24	4	4	0	3	1	0	1	4	108	375
MTD	209	494	0	0	130	3	4	14	11	120	32	37	17	50	144	28	24	113	108	1538
FFYTD	500	1144	0	442	322	7	14	29	34	347	60	89	37	96	505	48	56	226	298	4254
December																				
Approved	147	300	2	0	104	5	1	16	4	22	26	43	11	38	79	22	10	172	0	1002
Denied	13	11	0	0	5	1	1	1	0	20	2	6	1	3	4	2	17	14	0	101
Suspended	52	134	2	0	28	2	1	9	0	12	5	14	4	8	5	1	5	7	110	399
MTD	212	445	4	0	137	8	3	26	4	54	33	63	16	49	88	25	32	193	110	1502
FFYTD	712	1589	4	442	459	15	17	55	38	401	93	152	53	145	593	73	88	419	408	5756
January																				
Approved	176	519	2	0	166	5	6	48	8	28	5	49	20	48	120	19	12	187	0	1418
Denied	13	9	1	0	2	3	1	1	1	25	0	1	0	2	2	4	26	5	0	96
Suspended	110	263	0	0	31	0	4	14	1	61	1	20	6	14	2	2	10	17	96	652
MTD	299	791	3	0	199	8	11	63	10	114	6	70	26	64	124	25	48	209	96	2166
FFYTD	1011	2380	7	442	658	23	28	118	48	515	99	222	79	209	717	98	136	628	504	7922
February																				
Approved	285	690	0	0	105	5	14	34	12	24	1	43	14	40	102	17	4	109	0	1499
Denied	6	6	0	0	2	1	0	0	0	12	0	2	0	4	2	2	18	3	0	58
Suspended	89	181	0	0	34	1	5	10	4	17	1	14	2	11	2	1	6	8	94	480
MTD	380	877	0	0	141	7	19	44	16	53	2	59	16	55	106	20	28	120	94	2037
FFYTD	1391	3257	7	442	799	30	47	162	64	568	101	281	95	264	823	118	164	748	598	9959
March																				
Approved	316	750	5	0	98	20	9	36	8	28	0	42	23	56	70	19	6	153	0	1639
Denied	5	10	0	0	0	2	2	0	1	5	0	1	0	3	3	1	25	0	0	58
Suspended	88	167	2	0	30	5	6	13	0	11	0	12	4	3	3	1	8	11	43	407
MTD	409	927	7	0	128	27	17	49	9	44	0	55	27	62	76	21	39	164	43	2104
FFYTD	1800	4184	14	442	927	57	64	211	73	612	101	336	122	326	899	139	203	912	641	12063
April																				
Approved	433	698	8	0	718	63	6	37	5	38	0	69	34	102	46	31	4	385	0	2677
Denied	8	1	0	0	4	21	1	0	0	3	0	1	1	2	1	1	16	5	0	65
Suspended	97	109	2	0	41	26	0	2	1	7	0	22	3	15	0	2	0	8	57	392
MTD	538	808	10	0	763	110	7	39	6	48	0	92	38	119	47	34	20	398	57	3134
FFYTD	2338	4992	24	442	1690	167	71	250	79	660	101	428	160	445	946	173	223	1310	698	15197
May																				
Approved	106	984	6	0	500	31	4	17	5	9		67	10	32	2	22	3	122	0	1920
Denied	8	12	0	0	2	1	0	0	4	5		0	1	5	0	0	6	1	0	45
Suspended	25	216	0	0	55	12	2	11	0	4		12	0	0	0	2	0	6	27	372
MTD	139	1212	6	0	557	44	6	28	9	18	0	79	11	37	2	24	9	129	27	2337
FFYTD	2477	6204	30	442	2247	211	77	278	88	678	101	507	171	482	948	197	232	1439	725	17534
June																				
Approved	7	813	9	0	285	40	4	19	0	13	0	68	1	1	0	25	0	2	0	1287
Denied	6	24	0	0	7	4	3	0	0	0	0	1	0	0	0	3	0	0	0	48
Suspended	2	241	2	0	48	17	3	8	0	3	0	10	0	0	0	0	0	0	9	343
MTD	15	1078	11	0	340	61	10	27	0	16	0	79	1	1	0	28	0	2	9	1678
FFYTD	2492	7282	41	442	2587	272	87	305	88	694	101	586	172	483	948	225	232	1441	734	19212
July																				
Approved	5	624	5	0	327	37	8	19	0	35	0	69	0	0	0	4	0	1	0	1134
Denied	1	20	0	0	1	4	1	0	0	1	0	1	0	0	0	2	0	0	0	31
Suspended	2	202	0	0	60	14	2	20	0	9	0	16	0	0	0	0	0	0	11	336
MTD	8	846	5	0	388	55	11	39	0	45	0	86	0	0	0	6	0	1	11	1501
FFYTD	2500	8126	46	442	2975	327	98	344	88	739	101	672	172	483	948	231	232	1442	745	20713
August																				
Approved	0	635	0	0	682	28	3	12	0	38	0	76	0	0	16	0	0	3	0	1493
Denied	0	7	0	0	2	4	0	0	0	4	0	0	0	0	0	0	0	2	0	19
Suspended	0	183	0	0	40	16	0	7	0	10	0	24	0	0	1	0	0	0	0	281
MTD	0	825	0	0	724	48	3	19	0	52	0	100	0	0	17	0	0	5	0	1793
FFYTD	2500	8953	46	442	3699	375	101	363	88	791	101	772	172	483	965	231	232	1447	745	22506
September																				
Approved	1	516	0	0	9	23	5	13	0	57	0	41	0	0	123	0	0	0	0	788
Denied	0	8	0	0	1	3	0	0	0	4	0	0	0	0	0	0	0	0	0	16
Suspended	0	199	0	0	1	10	3	15	0	4	0	28	0	0	17	0	0	0	0	277
MTD	1	723	0	0	11	36	8	28	0	65	0	69	0	0	140	0	0	0	0	1081
FFYTD	2501	9676	46	442	3710	411	109	391	88	856	101	841	172	483	1105	231	232	1447	745	23587

ATTACHMENT 2.2.C ProDUR Hard Edits:
PREFERRED DRUG LIST (PDL) PROGRAM PA ACTIVITY

State Healthcare Solutions, PBM Group

PDL Program – PA Activity*†
Contractor: ACS State Healthcare
(Reporting Dates: 4/01/2003 to 9/30/2003)

ACS Prior Authorization (PA) Summary	
PA Type	**Count of Interventions**
Information Only Calls – PDL Program	2,839
Regular PA Program††	45,243 ††
IRDP PA Program	1,131
PDL PA Program*	32,802
SUM:	**82,015**

* PDL Program was phased-in as the IRDP Program was phased-out during FFY 2003.

† ACS State Healthcare Call Center took calls for the other programs (Info only, Regular PA, IRDP) in addition to the PDL PA Activity calls as contractors and programs transitioned.

†† This number is a combination of PA's that ACS processed & active PA's that were migrated over into ACS's claims system from EDS.

ATTACHMENT 2.2.C --continued-- ProDUR Hard Edits: PDL PA Activity

ACS Therapeutic Consultation Program

Information Only Calls – PDL Program

Reporting Dates: 04/01/2003 to 09/30/2003

Therapeutic Class	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03
ACE Inhibitors	4	6	4			26
ACEI with CCB		1				3
ACEI with Diuretics						1
Angiotensin Receptor Blockers (ARBs)	14	12	7		6	39
Antidiabetic Agents		15	6		1	12
Antiemetic - Antivertigo Agents			1			2
Antifungal Oral	1	3	1		1	6
Antifungal Topicals						16
Antiulcer - H Pyloric Agents						1
Antiviral Anti-herpetic Agents					3	10
ARBs with Diuretics	4	3	2		2	10
Beta Adrenergic Blockers					1	1
Bile Acid Sequestrants		5	7		3	8
Brand Name Narcotics		6	2	1	2	9
Brand NSAIDS					1	1
Calcium Channel Blockers	1	2				3
Cephalosporins		1				7
Diflucan 150mg 2 Tablet Limit PDLDIFLUCAN		1				2
Duragesic		5	3		2	11
Fibric Acids						5
Fluoroquinolones		1			1	7
Forteo					6	
H2 Antagonists			1			1
Heparin and Related Products			2			
HMG CoA Reductase Inhibitors	11	14	3	1	3	11
Imitrex Stat Dose Month Limit						3
Imitrex Tablets Month Limit	1	1				1
Information- Discussion					247	1,447
Inhaled Glucocorticoids		3				10
Leukocyte Stimulants						2
Leukotriene Receptor Antagonists	2	1				2
Long Acting Beta Agonists			2			3
Loop Diuretics						1
Macrolides						1
Miotics - OIPR					2	9
Nasal Anti-Inflammatory Steroids		1				
Non-Sedating Antihistamines	1	6	4		4	28
Ophthalmic Antibiotics						7
Ophthalmic Mast Cell Stabilizers					2	9
Otic Antibiotics					2	1
Oxycodone and Hydrocodone APAP		2	3			3
Oxycodone IR			3			
Oxycontin		1	1		2	5
Platelet Aggregation Inhibitors	1					4
Prior Authorization		4			10	10
Proton Pump Inhibitors	13	26	25	1	20	269
Retin A						1
SERMS - Bone Resorption Agents	2	4	3		1	3
Short Acting Beta Agonists	2	1	1		2	14

ATTACHMENT 2.2.C --continued-- ProDUR Hard Edits: PDL PA Activity

ACS Therapeutic Consultation Program

Information Only Calls – PDL Program

Therapeutic Class	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03
Skeletal Muscle Relaxants		22	15	1	7	27
Smoking Deterrent Agents						1
Systemic Vitamin A Derivatives					4	23
Target Brand Thiazolidinediones						1
Thiazolidinediones	3	9	1		4	35
Triptans	4	4	3		1	6
Ultracet						12
Ultram and Ultracet		2	1		1	5
Urinary Tract Antispasmodics- Antiincontinence		5	10			3
Vaginal Antimicrobials					2	10
Zithromax Limit - PDLZPAK						2
Sum:	**64**	**167**	**111**	**4**	**343**	**2,150**

ATTACHMENT 2.2.C --continued-- ProDUR Hard Edits: PDL PA Activity

ACS Therapeutic Consultation Program

Regular PA Program

Reporting Date: 04/01/2003 to 09/30/2003

Therapeutic Class	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03
34 Day Supply (non-maintenance drugs are limited to 34 day supply)	7	16	19	5	3	5
Brand Medically Necessary	41	39	21	53	65	70
Drug-Drug Severity Level One	371	240	200	171	114	234
Early Refill	6,158	6,297	5,450	5,047	4,418	5,026
High Dose	3,351	1,505	1,023	750	638	641
Therapeutic Duplication	51	14	46	144	514	2,496
Sum:	9,979	8,111	6,759	6,170	5,752	8,472

IRDP PA Program

Therapeutic Class	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03
Carafate (Sucralfate)	88	40	48	41	36	29
Cytotec	8	5	6	7	3	9
Growth Hormones	35	21	21	25	12	15
Lactulose	69	80	76	72	73	59
Nutritional Supplements	4					
Synagis	46	3		1	25	172
Zithromax IRDP	1				1	
Sum:	**251**	**149**	**151**	**146**	**150**	**284**

PDL PA Program

Therapeutic Class	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03
ACE Inhibitors	35	46	52	55	55	49
ACEI with CCB	26	20	12	12	15	15
ACEI with Diuretics	3	4		1	3	1
Alpha Adrenergic Blockers	3				1	
Angiotensin Receptor Blockers (ARBs)	794	809	368	280	385	363
Antidiabetic Agents		140	198	62	68	45
Antiemetic - Antivertigo Agents	9	4	6	5	4	9
Antifungal Oral	69	58	100	69	161	72
Antifungal Topicals					167	146
Antipsoriatics					1	
Antiulcer - H Pyloric Agents					21	33
Antiviral Anti-herpetic Agents					10	14
Antiviral Influenza Agents					1	2
ARBs with Diuretics	51	32	26	16	14	20
Axert Month Limit	5	5				
Beta Adrenergic Blockers	11	8	8	7	9	3
Biaxin XL Month Limit PD LBIAXIN	1					
Bile Acid Sequestrants		20	46	17	18	14
Brand Name Narcotics		127	125	48	50	26
Brand NSAIDS	589	1,036	840	551	623	552
Calcium Channel Blockers	28	19	31	37	20	30

ATTACHMENT 2.2.C --continued-- ProDUR Hard Edits: PDL PA Activity

PDL PA Program Activity						
Therapeutic Class	**Apr-03**	**May-03**	**Jun-03**	**Jul-03**	**Aug-03**	**Sep-03**
Cephalosporins	32	56	44	28	25	35
Codeine with APAP			1			
Diflucan 150mg 2 Tablet Limit PDLDIFLUCAN	3	5	5	3	4	4
Duragesic	334	310	249	143	182	158
Fibric Acids					12	13
Fluoroquinolones	31	29	40	33	25	28
Forteo				4	18	9
H2 Antagonists	633	555	271	272	657	7
Heparin and Related Products			1			
HMG CoA Reductase Inhibitors	106	172	77	57	37	53
Imitrex Nasal Spray Month Limit				3	2	
Imitrex Stat Dose Month Limit	2	2		1	2	4
Imitrex Tablets Month Limit	8	14	4	1	4	4
Inhaled Glucocorticoids	89	68	85	59	89	84
Leukocyte Stimulants				2	3	5
Leukotriene Receptor Antagonists		1	1	1	1	1
Long Acting Beta Agonists	13	17	25	23	17	22
Loop Diuretics	1		1	3	1	4
Macrolides	7	16	11	14	11	11
Miotics - OIPR				11	30	16
Non-Sedating Antihistamines	190	175	192	123	166	182
Ophthalmic Antibiotics				40	83	56
Ophthalmic Mast Cell Stabilizers				2	11	18
Oral Antifungals					4	8
Otic Antibiotics					10	11
Oxycodone and Hydrocodone APAP	20	45	21	11	6	12
Oxycodone IR	29	14	7	6	3	
Oxycontin	85	112	79	47	80	47
Platelet Aggregation Inhibitors	3	14	9	9	7	12
Prior Authorization	79	55	28	39	100	29
PROPOXYPHENE WITH APAP		5	8	1	2	4
Proton Pump Inhibitors	305	713	943	694	708	3,154
Retin-A	26	19	19	7	1	2
SERMS - Bone Resorption Agents	248	148	88	84	91	55
Short Acting Beta Agonists	327	257	221	138	197	255
Skeletal Muscle Relaxants		184	282	84	92	83
Smoking Deterrent Agents				8	50	8
Stadol - NS	5	6				
Systemic Vitamin A Derivatives				10	32	42
Target Brand Angiotensin Receptor Antagonists			1	2		
Target Brand - Bone Resorption Suppression Agents	1					
Target Brand Thiazolidinediones			3	1		
Therapeutic Duplication	51	14	46	144	514	2,496
Thiazolidinediones	37	45	27	28	41	462
Triptans	56	47	36	35	40	30
Ultracet					11	3
Ultram and Ultracet	382	260	16	9	7	10
Urinary Tract Antispasmodics- Antiincontinence		36	95	37	30	16
Vaginal Antimicrobials					108	174
Zithromax Limit - PDLZPAK	13	12	6	7	8	12
Zofran Tablet Limit (10 tablets per Rx)	5	3				1
Sum:	**4,745**	**5,737**	**4,754**	**3,384**	**5,148**	**9,034**

Attachment 3:
RetroDUR Activity

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 3. RetroDUR ACTIVITY – FFY2003

ATTACHMENT 3 is a year end summary report on retrospective DUR screening and interventions.
Contractor 1: 10/1/02 to 3/22/03: EDS
Contractor 2: (Attachments 3.2-3.5) 3/23/03 to 9/30/03: ACS State Healthcare

Due to a mid-year change in contractors, two agents were responsible for analyzing pharmacy claims data. EDS was the agent responsible for RetroDUR activities from 10/01/2002 to 3/22/2003. ACS State Healthcare was the agent responsible for RetroDUR activities from 03/23/2003 to 09/30/2003.

RetroDUR Descriptive Overview

RetroDUR interventions were performed as approved by the DUR Board. The DUR Board met monthly to review proposed interventions. The proposed interventions were not always approved as some were modified to meet approval. ACS State Healthcare performed RetroDUR interventions only when the DUR Board approved an individual intervention.

Attachment 3.1 reports RetroDUR procedures used by the state of Indiana.
As required in the CMS instructions, Attachments 3.2 to 3.5 include:

1) Cover all criteria exceptions, and includes a denominator (% criteria exceptions / number of prescription claims adjudicated for a drug class or drug), and the number of interventions undertaken during the reporting period.

2) State which engage in physician, pharmacy profile analysis (i.e., review prescribing or dispensing of multiple prescriptions for multiple patients involving a particular problem type or diagnosis) or engage in patient profiling should report the number of each type of profile (physician, pharmacy, patient) reviewed and identify the subject(s) (diagnosis, problem type, etc.) involved.

The state of Indiana used ***three types of RetroDUR*** **interventions** :

1. Standard RetroDUR initiatives,
2. Intensive Benefits Management (IBM), and
3. Therapeutic Academic Interventions (TAI).

Standard RetroDUR intervention letters described potential drug therapy problem(s) in patient-specific situations. RetroDUR intervention letters may include the patient's current comprehensive drug history profile.

IBM interventions involved ACS pharmacists calling practitioners about targeted drug therapy problems. The IBM pharmacists encouraged practitioners to consider changing targeted recipients' therapy to a more appropriate drug therapy and discussed various alternatives with practitioners. TAI interventions involved large group meetings with targeted practitioners about drug therapy problems. A TAI pharmacist also conducted face-to-face office visits to educate targeted practitioners on specified drug therapy interventions.

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 3.1

Indiana RetroDUR Procedures

ACS State Healthcare assigned a Clinical Account Pharmacist to manage the state of Indiana's DUR programs and to interact with the DUR Board. ACS clinical pharmacists trained and experienced in DUR conducted the RetroDUR operations described as follows.

The RetroDUR Program involved both computerized and clinical pharmacist review of medication claims history. An initial computer-based screening of each individual patient claims history is performed using clinically based criteria. The purpose of the computer-based screening is to identify ***potential*** drug therapy problems.

ACS' Clinical Account Pharmacist presented the criteria and screening to the DUR Board. The presentation included incidence and prevalence of the drug therapy problem. The DUR Board reviewed the drug therapy problem criteria and educational materials. If the RetroDUR intervention was approved, ACS clinical pharmacists conducted the intervention.

Practitioner responses were requested on the drug therapy intervention and documented in a proprietary case management database. The responses were used to receive feedback to assess the success of initiatives performed. ACS measures prescribers' actions resulting from the letters. Evaluations of claims are performed 3 to 6 months post-intervention to determine the effectiveness of the educational interventions.

ATTACHMENT 3.2 RETRODUR EXCEPTIONS (PATIENTS' SCREENED) & INTERVENTIONS BY THERAPEUTIC CLASS

IFIC TX CLASS	TARGET AHFS DESCRIPTION	RX COUNT	COUNT UNIQUE UTILIZERS	PATIENTS SCREENED	PATIENTS TARGETED	IBM INTERVENTIONS	TAI INTERVENTIONS	TAI PDL TARGETED EDUCATION[2]	RetroDUR INTERVENTIONS	INTERVENTION TYPE
A1A	DIGITALIS GLYCOSIDES	88,638	12,832	0	0	0	0	0	0	
A1B	XANTHINES	25,009	3,685	872	764	0	0	0	495	UU
A1C	INOTROPIC DRUGS	171	11	0	0	0	0	0	0	
A1D	GENERAL BRONCHODILATOR AGENTS	32,670	8,021	0	0	0	0	0	0	
A2A	ANTIARRHYTHMICS	17,661	2,944	0	0	0	0	0	0	
A4A	HYPOTENSIVES, VASODILATORS	9,981	1,859	0	0	0	0	0	0	
A4B	HYPOTENSIVES, SYMPATHOLYTIC	66,071	11,174	0	0	0	0	0	0	
A4C	GANGLIONIC BLOCKERS, HYPOTENSIVES	54	8	0	0	0	0	0	0	
A4D	ACE INHIBITORS, HYPOTENSIVES	263,035	40,395	1,610	1,586	1,586	0	0	0	ED
A4D	ACE INHIBITORS, HYPOTENSIVES	263,035	40,395	1,695	1,695	0	0	1,695	0	ED
A4D	ACEIs/DIURETIC	263,035	40,395	12,769	12,769	0	0	12,769	0	ED
A4F	ANGIOTENSIN RECEPTOR ANTAG. HYPOTENSIVES	71,691	12,947	1,739	1,686	1,686	0	0	0	ED
A4F	ANGIOTENSIN RECEPTOR ANTAG. HYPOTENSIVES	71,691	12,947	4,685	4,685	0	0	4,685	0	ED
A4F	ANGIOTENSIN RECEPTOR ANTAG. HYPOTENSIVES	71,691	12,947	1,541	288	0	0	0	0	OU
A4F	ARBs/DIURETICS	71,691	12,947	12,769	12,769	0	0	12,769	0	ED
A4K	ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION	16,668	2,796	12,769	12,769	0	0	12,769	0	ED
A4Y	HYPOTENSIVES, MISCELLANEOUS	11,922	1,767	0	0	0	0	0	0	
A7B	VASODILATORS, CORONARY	127,564	21,044	0	0	0	0	0	0	
A7C	VASODILATORS, PERIPHERAL	643	111	0	0	0	0	0	0	
A7H	VASOACTIVE NATRIURETIC PEPTIDES	11	2	0	0	0	0	0	0	
A9A	CALCIUM CHANNEL BLOCKING AGENTS	219,712	31,773	1,594	1,594	0	0	1,594	0	ED
A9A	SORT ACTING CALCIUM CHANNEL BLOCKING AGENTS	219,712	31,773	437	437	0	0	0	0	OU
B0A	GENERAL INHALATION AGENTS	6,996	4,924	0	0	0	0	0	0	
B1B	PULMONARY ANTI-HTN, ENDOTHELIN RECEPT ANTAG.	102	21	0	0	0	0	0	0	
B1C	PULMONARY ANTI-HTN, PROSTACYCLIN-TYPE	63	6	0	0	0	0	0	0	
B3A	MUCOLYTICS	2,078	665	0	0	0	0	0	0	
B3J	EXPECTORANTS	141,558	66,116	0	0	0	0	0	0	
B3K	COUGH AND/OR COLD PREPARATIONS	145,691	82,185	0	0	0	0	0	0	
C0B	WATER	4,214	1,339	0	0	0	0	0	0	
C0D	ANTI-ALCOHOLIC PREPARATIONS	767	207	0	0	0	0	0	0	
C0K	BICARBONATE PRODUCING/CONTAINING AGENTS	1,587	274	0	0	0	0	0	0	
C1A	ELECTROLYTE DEPLETERS	16,487	3,134	0	0	0	0	0	0	
C1B	SODIUM/SALINE PREPARATIONS	17,671	3,729	0	0	0	0	0	0	
C1D	POTASSIUM REPLACEMENT	186,240	29,961	0	0	0	0	0	0	
C1F	CALCIUM REPLACEMENT	121,147	16,907	0	0	0	0	0	0	
C1H	MAGNESIUM SALTS REPLACEMENT	3,836	722	0	0	0	0	0	0	
C1P	PHOSPHATE REPLACEMENT	672	114	0	0	0	0	0	0	
C1W	ELECTROLYTE MAINTENANCE	3,329	1,921	0	0	0	0	0	0	
C3B	IRON REPLACEMENT	87,357	22,503	0	0	0	0	0	0	
C3C	ZINC REPLACEMENT	14,672	3,609	0	0	0	0	0	0	
C3H	IODINE CONTAINING AGENTS	290	136	0	0	0	0	0	0	
C3M	MINERAL REPLACEMENT, MISCELLANEOUS	986	78	0	0	0	0	0	0	
C4G	INSULINS	164,161	18,922	0	0	0	0	0	0	
C4K	HYPOGLYCEMICS, INSULIN-RELEASE STIM. TYPE	123,359	17,259	4,053	4,053	0	0	4,053	0	ED
C4K	ANTIDIABETIC COMBOS	123,359	17,259	4,053	4,053	0	0	4,053	0	ED
C4L	HYPOGLYCEMICS, BIGUANIDE TYPE (NON-SULFONYLUREAS)	74,573	11,988	0	0	0	0	0	0	
C4M	HYPOGLYCEMICS, ALPHAGLUCOSIDASE INHIB TYPE (N-S)	2,073	358	0	0	0	0	0	0	
C4N	HYPOGLYCEMICS, INSULIN-RESPONSE ENHANCER (N-S)	68,672	10,672	12,769	12,769	1,470	488	12,769	0	ED
C5B	PROTEIN REPLACEMENT	1,077	94	0	0	0	0		0	
C5C	INFANT FORMULAS	450	131	0	0	0	0		0	
C5F	DIETARY SUPPLEMENT, MISCELLANEOUS	1,553	444	0	0	0	0		0	
C5G	FOOD OILS	11	7	0	0	0	0		0	
C5J	IV SOLUTIONS: DEXTROSE-WATER	4,291	842	0	0	0	0		0	
C5K	IV SOLUTIONS: DEXTROSE-SALINE	2,535	1,005	0	0	0	0		0	

ATTACHMENT 3.2 --continued-- RetroDUR Exceptions & Interventions

IFIC TX CLASS	TARGET AHFS DESCRIPTION	RX COUNT	COUNT UNIQUE UTILIZERS	PATIENTS SCREENED	PATIENTS TARGETED	IBM INTERVENTIONS	TAI INTERVENTIONS[1]	TAI PDL TARGETED EDUCATION[2]	RetroDUR INTERVENTIONS	INTERVENTION TYPE
C5L	IV SOLUTIONS: DEXTROSE/RINGERS	4	3	0	0	0	0	0	0	
C5M	IV SOLUTIONS: DEXTROSE/LACTATED RINGERS	166	52	0	0	0	0	0	0	
C5O	SOLUTIONS MISCELLANEOUS	33	6	0	0	0	0	0	0	
C5U	NUTRITIONAL THERAPY, MED COND SPECIAL FORMULATION	170	60	0	0	0	0	0	0	
C6A	VITAMIN A PREPARATIONS	26	8	0	0	0	0	0	0	
C6B	VITAMIN B PREPARATIONS	13,504	2,174	0	0	0	0	0	0	
C6C	VITAMIN C PREPARATIONS	34,809	6,370	0	0	0	0	0	0	
C6D	VITAMIN D PREPARATIONS	3,722	723	0	0	0	0	0	0	
C6E	VITAMIN E PREPARATIONS	32,600	4,493	0	0	0	0	0	0	
C6F	PRENATAL VITAMIN PREPARATIONS	37,482	18,538	0	0	0	0	0	0	
C6G	GERIATRIC VITAMIN PREPARATIONS	991	285	0	0	0	0	0	0	
C6H	PEDIATRIC VITAMIN PREPARATIONS	10,502	4,174	0	0	0	0	0	0	
C6K	VITAMIN K PREPARATIONS	1,278	584	0	0	0	0	0	0	
C6L	VITAMIN B12 PREPARATIONS	18,603	3,572	0	0	0	0	0	0	
C6M	FOLIC ACID PREPARATIONS	35,827	6,213	0	0	0	0	0	0	
C6N	NIACIN PREPARATIONS	746	170	0	0	0	0	0	0	
C6Q	VITAMIN B6 PREPARATIONS	4,411	893	0	0	0	0	0	0	
C6R	VITAMIN B2 PREPARATIONS	46	15	0	0	0	0	0	0	
C6T	VITAMIN B1 PREPARATIONS	6,801	1,225	0	0	0	0	0	0	
C6Z	MULTIVITAMIN PREPARATIONS	224,228	30,671	0	0	0	0	0	0	
C7A	HYPERURICEMIA TX - PURINE INHIBITORS	22,535	3,481	0	0	0	0	0	0	
C7B	DECARBOXYLASE INHIBITORS	97	15	0	0	0	0	0	0	
C7D	METABOLIC DEFICIENCY AGENTS	2,538	284	0	0	0	0	0	0	
C8A	METALLIC POISON, AGENTS TO TREAT	588	52	0	0	0	0	0	0	
D1A	PERIODONTAL COLLAGENASE INHIBITORS	591	200	0	0	0	0	0	0	
D1D	DENTAL AIDS AND PREPARATIONS	12,648	5,802	0	0	0	0	0	0	
D2A	FLUORIDE PREPARATIONS	5,435	3,200	0	0	0	0	0	0	
D4B	ANTACIDS	36,947	9,768	0	0	0	0	0	0	
D4E	ANTI-ULCER PREPARATIONS	8,103	2,302	0	0	0	0	0	0	
D4F	ANTI-ULCER -H.PYLORI AGENTS	684	626	0	0	0	0	0	0	
D4G	GASTRIC ENZYMES	1,870	253	0	0	0	0	0	0	
D4H	ORAL MUCOSITIS/STOMATITIS AGENTS	2	2	0	0	0	0	0	0	
D4I	ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT	152	128	0	0	0	0	0	0	
D4K	ANTI ULCER/H PYLORI AGENTS	449,348	75,257	7,048	7,048	0	0	7,048	0	ED
D4K	H2 INHIBITORS	449,348	75,257	29,198	861	0	0	0	0	U U
D4K	PPIs	449,348	75,257	7,336	1,108	0	0	0	0	O U
D4K	PPIs	449,348	75,257	488	488	0	488	0	0	ED
D4K	PPIs	449,348	75,257	1,695	1,695	0	0	4,695	0	ED
D4K	PPIs	449,348	75,257	29,198	861	0	0	0	0	O U
D4N	ANTIFLATULENTS	3,924	981	0	0	0	0	0	0	
D5A	FAT ABSORPTION DECREASING AGENTS	212	125	0	0	0	0	0	0	
D5P	INTESTINAL ADSORBENTS AND PROTECTIVES	40	31	0	0	0	0	0	0	
D6A	DRUGS TO TX CHRONIC INFLAMM. DISEASE OF COLON	43	11	0	0	0	0	0	0	
D6C	IRRITABLE BOWEL SYND. AGENT, 5HT-3 ANTAG. -TYPE	37	20	0	0	0	0	0	0	
D6D	ANTIDIARRHEALS	31,477	14,780	0	0	0	0	0	0	
D6E	IRRITABLE BOWEL SYND. AGENT, 5HT-4 PARTIAL AGONIST	4,516	1,721	0	0	0	0	0	0	
D6F	DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT	4,445	895	0	0	0	0	0	0	
D6S	LAXATIVES AND CATHARTICS	301,931	49,185	0	0	0	0	0	0	
D7A	BILE SALTS	1,618	321	0	0	0	0	0	0	
D7D	DRUGS TO TREAT HEREDITARY TYROSINEMIA	11	1	0	0	0	0	0	0	
D7L	BILE SALT SEQUESTRANTS	6,043	1,835	4,053	4,053	0	0	4,053	0	ED
D8A	PANCREATIC EN ZYMES	5,734	1,104	0	0	0	0	0	0	
D9A	AMMONIA INHIBITORS	1,665	444	0	0	0	0	0	0	

ATTACHMENT 3.2 --continued-- RetroDUR Exceptions & Interventions

IFIC TX CLASS	TARGET AHFS DESCRIPTION	RX COUNT	COUNT UNIQUE UTILIZERS	PATIENTS SCREENED	PATIENTS TARGETED	IBM INTERVENTIONS	TAI INTERVENTIONS[2]	TAI PDL TARGETED EDUCATION[2]	RetroDUR INTERVENTIONS	INTERVENTION TYPE
F1A	ANDROGENIC AGENTS	3,483	864	0	0	0	0	0	0	
F2A	DRUGS TO TREAT IMPOTENCY	27	21	0	0	0	0	0	0	
G1A	ESTROGENIC AGENTS	86,572	14,045	0	0	0	0	0	0	
G1B	ESTROGEN/ANDROGEN COMBINATIONS	4,426	797	0	0	0	0	0	0	
G2A	PROGESTATIONAL AGENTS	10,671	3,439	0	0	0	0	0	0	
G3A	OXYTOCICS	447	420	0	0	0	0	0	0	
G8A	CONTRACEPTIVES, ORAL	65,938	16,069	0	0	0	0	0	0	
G8C	CONTRACEPTIVES, INJECTABLE	8,871	4,164	0	0	0	0	0	0	
G8F	CONTRACEPTIVES, TRANSDERMAL	15,947	5,432	0	0	0	0	0	0	
G9A	CONTRACEPTIVES, INTRAVAGINAL	9	5	0	0	0	0	0	0	
G9B	CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC	725	319	0	0	0	0	0	0	
H0A	LOCAL ANESTHETICS	7,891	5,123	0	0	0	0	0	0	
H0E	AGENTS TO TREAT MULTIPLE SCLEROSIS	4,722	634	0	0	0	0	0	0	
H2A	CENTRAL NERVOUS SYSTEM STIMULANTS	765	142	0	0	0	0	0	0	
H2C	GENERAL ANESTHETICS, INJECTABLE	129	83	0	0	0	0	0	0	
H2D	BARBITURATES	29,609	3,011	0	0	0	0	0	0	
H2E	SEDATIVE-HYPNOTICS, NON-BARBITURATE	97,345	22,455	0	0	0	0	0	0	
H2F	ANTI-ANXIETY DRUGS	340,382	53,534	0	0	0	0	0	0	
H2G	ANTI-PSYCHOTICS, PHENOTHIAZINES	27,982	3,617	0	0	0	0	0	0	
H2J	ANTIDEPRESSANTS O.U.	8	6	0	0	0	0	0	0	
H2L	ANTI-PSYCHOTICS, NON-PHENOTHIAZINES	10	3	0	0	0	0	0	0	
H2M	ANTI-MANIA DRUGS	26,490	3,719	0	0	0	0	0	0	
H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	465,064	78,264	2,302	1,058	1,058	0	0	0	DO
H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	465,064	78,264	3,879	3,879	0	0	0	0	TD
H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	465,064	78,264	188	188	0	188	0	0	DO
H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	465,064	78,264	101	101	0	101	0	0	DO
H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	465,064	78,264	5,119	5,119	0	0	0	0	DO
H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	88,990	17,682	0	0	0	0	0	0	
H2V	TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY	103,487	16,669	0	0	0	0	0	0	
H2W	TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS	2,112	335	0	0	0	0	0	0	
H2X	TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS	727	140	0	0	0	0	0	0	
H3A	ANALGESICS, NARCOTICS	801,302	146,257	4,053	4,053	0	0	4,053	0	ED
H3A	ULTRACET	801,302	146,257	4,035	4,035	0	0	4,053	0	ED
H3C	ANALGESICS, NON-NARCOTICS	8	2	0	0	0	0	0	0	
H3D	ANALGESIC/ANTIPYRETICS, SALICYLATES	155,787	24,597	0	0	0	0	0	0	
H3E	ANALGESIC/ANTIPYRETICS, NON-SALICYLATE	176,080	48,845	0	0	0	0	0	0	
H3F	ANTIMIGRAINE PREPARATIONS	39,269	11,057	12,769	12,769	0	0	12,769	0	ED
H3H	ANALGESICS NARCOTIC, ANESTHETIC ADJUNCT AGENTS	2	2	0	0	0	0	0	0	
H3T	NARCOTIC ANTAG.	1,901	330	0	0	0	0	0	0	

ATTACHMENT 3.2 --continued-- RetroDUR Exceptions & Interventions

IFIC TX CLASS	TARGET AHFS DESCRIPTION	RX COUNT	COUNT UNIQUE UTILIZERS	PATIENTS SCREENED	PATIENTS TARGETED	IBM INTERVENTIONS	TAI INTERVENTIONS	TAI PDL TARGETED EDUCATION	RetroDUR INTERVENTIONS	INTERVENTION TYPE
H4B	ANTICONVULSANTS-DEPAKOTE	550,354	59,155	3,315	3,315	0	0	0	0	DO
H6A	ANTIPARKINSONISM DRUGS, OTHER	46,621	5,397	0	0	0	0	0	0	
H6B	ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC	49,220	6,518	0	0	0	0	0	0	
H6C	ANTITUSSIVES, NON-NARCOTIC	10,788	6,314	0	0	0	0	0	0	
H6E	EMETICS	7	7	0	0	0	0	0	0	
H6H	SKELETAL MUSCLE RELAXANTS	155,891	36,057	4,053	4,053	0	0	4,053	0	ED
H6H	SKELETAL MUSCLE RELAXANTS	155,891	36,057	345	345	0	0	0	0	TD
H6H	SKELETAL MUSCLE RELAXANTS	155,891	36,057	688	616	0	0	0	0	TD
H6I	AMYOTROPHIC LATERAL SCLEROSIS AGENTS	176	23	0	0	0	0	0	0	
H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	56,584	26,222	4,685	4,685	0	0	4,685	0	ED
H7B	ALPHA2 RECEPTOR ANTAG. ANTIDEPRESSANTS	76,887	13,648	0	0	0	0	0	0	
H7C	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	67,236	11,902	0	0	0	0	0	0	
H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	64,492	15,100	0	0	0	0	0	0	
H7E	SEROTONIN-2 ANTAG. /REUPTAKE INHIBITORS (SARIS)	81,502	16,218	0	0	0	0	0	0	
H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	153	31	0	0	0	0	0	0	
H7N	SMOKING DETERRENTS, OTHER	906	592	0	0	0	0	0	0	
H7O	ANTIPSYCHOTICS, DOPAMINE ANTAG.BUTYROPHENONES	22,781	3,948	0	0	0	0	0	0	
H7P	ANTIPSYCHOTICS, DOPAMINE ANTAG. THIOXANTHENES	4,720	580	0	0	0	0	0	0	
H7R	ANTIPSYCH, DOPAMINE ANTAG.DIPHENYLBUTYLPIPERIDINES	359	62	0	0	0	0	0	0	
H7S	ANTIPSYCHOTICS, DOPAMINE ANTAG.DIHYDROINDOLONES	586	70	0	0	0	0	0	0	
H7T	ANTIPSYCHOTICS, ATYPICAL, DOPAMINE, SEROTONIN ANTAG	443,354	48,408	0	0	0	0	0	0	
H7U	ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAG.	2,837	334	0	0	0	0	0	0	
H7W	ANTI-NARCOLEPSY/ANTI-CATAPLEXY, SEDATIVE-TYPE AGNT	12	8	0	0	0	0	0	0	
H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	14,817	3,913	0	0	0	0	0	0	
H7Y	TX FOR ATTENTION DEFICIT-HYPERACT. (ADHD), NRI-TYPE	25,264	7,465	0	0	0	0	0	0	
J1A	PARASYMPATHETIC AGENTS	2,436	525	0	0	0	0	0	0	
J1B	CHOLINESTERASE INHIBITORS	68,769	9,346	0	0	0	0	0	0	
J2A	BELLADONNA ALKALOIDS	14,546	5,031	0	0	0	0	0	0	
J2B	ANTICHOLINERGICS, QUATERNARY AMMONIUM	3,542	713	0	0	0	0	0	0	
J2D	ANTICHOLINERGICS/ANTISPASMODICS	14,091	5,279	0	0	0	0	0	0	
J3A	SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)	9,852	5,046	4,035	4,035	0	0	4,035	0	ED
J5A	ADRENERGIC AGENTS, CATECHOLAMINES	156	139	0	0	0	0	0	0	
J5B	ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	78,179	13,040	0	0	0	0	0	0	
J5D	ALBUTEROL INHALER	281,474	83,948	872	764	0	0	0	495	OU
J5D	SEREVENT	281,474	83,948	623	623	0	0	0	0	OU
J5E	SYMPATHOMIMETIC AGENTS	7,241	3,917	0	0	0	0	0	0	
J5F	ANAPHYLAXIS THERAPY AGENTS	2,819	2,168	0	0	0	0	0	0	
J5G	BETA-ADRENERGICS AND GLUCOCORTICOIDS COMBINATION	42,658	12,758	0	0	0	0	0	0	
J5H	ADRENERGIC VASOPRESSOR AGENTS	1,557	311	0	0	0	0	0	0	
J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	19,732	3,555	1,594	1,594	0	0	1,594	0	ED
J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	25,335	3,596	1,594	1,594	0	0	1,594	0	ED
J7C	BETA-ADRENERGIC BLOCKING AGENTS	221,343	34,309	1,594	1,594	0	0	1,594	0	ED
J7C	LA/SA BETA AGONISTS	221,343	34,309	12,769	12,769	0	0	12,769	0	ED
J8A	ANOREXIC AGENTS	4	2	0	0	0	0	0	0	
J9A	INTESTINAL MOTILITY STIMULANTS	49,650	12,172	0	0	0	0	0	0	
J9B	ANTISPASMODIC AGENTS	45	13	0	0	0	0	0	0	
L0B	TOPICAL/MUCOUS MEMBR. /SUBCUT. ENZYMES	40,355	9,803	0	0	0	0	0	0	
L0C	DIABETIC ULCER PREPARATIONS, TOPICAL	1,223	429	0	0	0	0	0	0	
L1A	ANTIPSORIATIC AGENTS, SYSTEMIC	266	64	0	0	0	0	0	0	
L1B	ACNE AGENTS, SYSTEMIC	438	131	0	0	0	0	0	0	

ATTACHMENT 3.2 --continued-- RetroDUR Exceptions & Interventions

IFIC TX CLASS	TARGET AHFS DESCRIPTION	RX COUNT	COUNT UNIQUE UTILIZERS	PATIENTS SCREENED	PATIENTS TARGETED	IBM INTERVENTIONS	TAI INTERVENTIONS[1]	TAI PDL TARGETED EDUCATION[2]	RetroDUR INTERVENTIONS	INTERVENTION TYPE
L2A	EMOLLIENTS	16,988	8,134	0	0	0	0	0	0	
L3A	PROTECTIVES	4,740	1,810	0	0	0	0	0	0	
L3P	ANTIPRURITICS, TOPICAL	765	353	0	0	0	0	0	0	
L4A	ASTRINGENTS	40	28	0	0	0	0	0	0	
L5A	KERATOLYTICS	4,719	2,224	0	0	0	0	0	0	
L5E	ANTISEBORRHEIC AGENTS	5,489	2,840	0	0	0	0	0	0	
L5F	ANTIPSORIATICS AGENTS	3,479	1,382	4,035	4,035	0	0	4,035	0	ED
L5G	ROSACEA AGENTS, TOPICAL	1,328	715	0	0	0	0	0	0	
L5H	ACNE AGENTS, TOPICAL	5,123	2,681	0	0	0	0	0	0	
L6A	IRRITANTS/COUNTER-IRRITANTS	2,080	748	0	0	0	0	0	0	
L7A	SHAMPOOS/LOTION	95	47	0	0	0	0	0	0	
L8B	ANTIPERSPIRANTS	434	286	0	0	0	0	0	0	
L9A	TOPICAL AGENTS, MISCELLANEOUS	777	457	0	0	0	0	0	0	
L9B	VITAMIN A DERIVATIVES	4,789	2,673	4,035	4,035	0	0	4,035	0	ED
L9C	HYPOPIGMENTATION AGENTS	338	171	0	0	0	0	0	0	
L9D	TOPICAL HYPERPIGMENTATION AGENTS	1	1	0	0	0	0	0	0	
L9I	VITAMIN A DERIVATIVES, TOPICAL COSMETIC AGENTS	31	20	0	0	0	0	0	0	
L9J	HAIR GROWTH REDUCTION AGENTS	1	1	0	0	0	0	0	0	
M0B	PLASMA PROTEINS	102	13	0	0	0	0	0	0	
M0E	ANTIH EMOPHILIC FACTORS	1,659	70	0	0	0	0	0	0	
M0F	FACTOR IX PREPARATIONS	227	13	0	0	0	0	0	0	
M4A	BLOOD SUGAR DIAGNOSTICS	36,509	14,135	0	0	0	0	0	0	
M4B	IV FAT EMULSIONS	1,047	71	0	0	0	0	0	0	
M4E	FIBRIC ACIDS	257,682	35,207	4,053	4,053	0	0	4,053	0	ED
M4E	LIPOTROPICS	257,682	35,207	12,769	12,769	0	0	12,769	0	ED
M4E	LIPOTROPICS	257,682	35,207	19,465	247	0	0	0	188	DO
M4G	HYPERGLYCEMICS	3,979	1,657	0	0	0	0	0	0	
M9A	TOPICAL HEMOSTATICS	68	23	0	0	0	0	0	0	
M9D	ANTIFIBRINOLYTIC AGENTS	92	56	0	0	0	0	0	0	
M9E	THROMBIN INHIBITORS, SEL., DIRECT, &REV.-HIRUDIN	16	1	0	0	0	0	0	0	
M9F	THROMBOLYTIC ENZYMES	72	41	0	0	0	0	0	0	
M9K	HEPARIN AND RELATED PREPARATIONS	16,458	4,401	0	0	0	0	0	0	
M9L	ORAL ANTICOAGULANTS, COUMARIN TYPE	102,655	11,145	4,685	4,685	0	0	4,685	0	ED
M9M	ORAL ANTICOAGULANTS, INDANDIONE TYPE	4	1	0	0	0	0	0	0	
M9P	PLATELET AGGREGATION INHIBITORS	86,406	13,274	1,594	1,594	0	0	1,594	0	ED
M9S	HEMORRHEOLOGIC AGENTS	8,878	1,476	0	0	0	0	0	0	
N/A	ALL PDL AGENTS	N/A	N/A	4,377	501	501	0	0	0	OU
N/A	ALL PDL AGENTS	N/A	N/A	4,377	501	501	0	0	0	ED
N/A	ALL PDL AGENTS	N/A	N/A	488	488	0	488	0	0	OU
N/A	ALL PDL AGENTS	N/A	N/A	488	488	0	488	0	0	ED
N1B	HEMATINICS, OTHER	9,163	1,445	4,035	4,035	0	0	4,035	0	ED
N1C	LEUKOCYTE (WBC) STIMULANTS	811	197	4,035	4,035	0	0	4,035	0	ED
N1D	PLATELET REDUCING AGENTS	227	44	0	0	0	0	0	0	
N1E	PLATELET PROLIFERATION STIMULANTS	7	4	0	0	0	0	0	0	
P0A	FERTILITY STIMULATING PREPARATIONS, NON-FSH	16	11	0	0	0	0	0	0	
P0B	FOLLICLE STIM. /LUTEINIZING HORMONES	17	9	0	0	0	0	0	0	
P0C	PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL	22	11	0	0	0	0	0	0	
P1A	GROWTH HORMONES	1,874	244	0	0	0	0	0	0	
P1B	SOMATOSTATIC AGENTS	383	76	0	0	0	0	0	0	
P1E	ADRENOCORTICOTROPHIC HORMONES	43	18	0	0	0	0	0	0	
P1F	PITUITARY SUPPRESSIVE AGENTS	1,978	334	0	0	0	0	0	0	
P1M	LHRH AGONIST ANALOG PITUITARY SUPPRESSANTS	483	196	0	0	0	0	0	0	
P1P	LHRH AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	287	38	0	0	0	0	0	0	
P2B	ANTIDIURETIC AND VASOPRESSOR HORMONES	13,947	2,798	0	0	0	0	0	0	
P3A	THYROID HORMONES	190,638	23,929	0	0	0	0	0	0	
P3B	THYROID FUNCTION DIAGNOSTIC AGENTS	5	5	0	0	0	0	0	0	
P3L	ANTITHYROID PREPARATIONS	2,647	527	0	0	0	0	0	0	
P4B	BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE	160	64	4,035	4,035	0	0	4,035	0	ED

ATTACHMENT 3.2 --continued-- RetroDUR Exceptions & Interventions

IFIC TX CLASS	TARGET AHFS DESCRIPTION	RX COUNT	COUNT UNIQUE UTILIZERS	PATIENTS SCREENED	PATIENTS TARGETED	IBM INTERVENTIONS	TAI INTERVENTIONS[3]	TAI PDL TARGETED EDUCATION[4]	RetroDUR INTERVENTIONS	INTERVENTION TYPE
P4L	BONE RESORPTION INHIBITORS	99,475	14,740	1,313	1,302	1,302	0	0	0	ED
P4L	BONE RESORPTION INHIBITORS	99,475	14,740	1,516	0	0	0	0	0	ED
P4L	BONE RESORPTION INHIBITORS	99,475	14,740	4,685	4,685	0	0	4,685	0	ED
P5A	GLUCOCORTICOIDS INHALERS	168,085	65,435	12,769	12,769	0	0	12,769	0	ED
P5A	GLUCOCORTICOIDS INHALERS	168,085	65,435	872	764	0	0	0	495	UU
P5S	MINERALOCORTICOIDS	3,595	638	0	0	0	0	0	0	
Q2C	OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE	320	122	0	0	0	0	0	0	
Q2U	EYE DIAGNOSTIC AGENTS	11	11	0	0	0	0	0	0	
Q3A	RECTAL PREPARATIONS	5,633	3,223	0	0	0	0	0	0	
Q3B	RECTAL/LOWER BOWEL PREP.GLUCOCORT. (NON-HEMORR)	87	43	0	0	0	0	0	0	
Q3D	HEMORRHOIDAL PREPARATIONS	1,342	731	0	0	0	0	0	0	
Q3E	CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX	272	120	0	0	0	0	0	0	
Q3H	HEMORRHOIDALS, LOCAL RECTAL ANESTHETICS	161	106	0	0	0	0	0	0	
Q3S	LAXATIVES, LOCAL/RECTAL	27,066	9,155	0	0	0	0	0	0	
Q4A	VAGINAL PREPARATIONS	124	109	0	0	0	0	0	0	
Q4B	VAGINAL ANTISEPTICS	55	33	0	0	0	0	0	0	
Q4F	VAGINAL ANTIFUNGALS	7,978	6,088	7,048	7,048	0	0	7,048	0	ED
Q4K	VAGINAL ESTROGEN PREPARATIONS	4,159	2,068	7,048	7,048	0	0	7,048	0	ED
Q4S	VAGINAL SULFONAMIDES	97	77	0	0	0	0	0	0	
Q4W	VAGINAL ANTIBIOTICS	4,699	3,991	0	0	0	0	0	0	
Q5A	TOPICAL PREPARATIONS, MISCELLANEOUS	269	91	0	0	0	0	0	0	
Q5B	TOPICAL PREPARATIONS, ANTIBACTERIALS	1,299	672	0	0	0	0	0	0	
Q5F	TOPICAL ANTIFUNGALS	99,680	45,905	7,048	7,048	0	0	7,048	0	ED
Q5H	TOPICAL LOCAL ANESTHETICS	9,911	3,611	0	0	0	0	0	0	
Q5K	TOPICAL IMMUNOSUPPRESSIVE AGENTS	12,953	7,521	0	0	0	0	0	0	
Q5N	TOPICAL ANTINEOPLASTIC & PREMALIGNANT LESION AGNTS	285	197	0	0	0	0	0	0	
Q5P	TOPICAL ANTI-INFLAMMATORY STEROIDAL	78,219	38,424	0	0	0	0	0	0	
Q5R	TOPICAL ANTIPARASITICS	26,983	18,319	0	0	0	0	0	0	
Q5S	TOPICAL SULFONAMIDES	11,665	5,311	0	0	0	0	0	0	
Q5V	TOPICAL ANTIVIRALS	5,656	3,755	0	0	0	0	0	0	
Q5W	TOPICAL ANTIBIOTICS	70,572	33,603	0	0	0	0	0	0	
Q5X	TOPICAL ANTIBIOTICS/ANTIINFLAMMATORY, STEROIDAL	306	170	0	0	0	0	0	0	
Q6A	OPHTHALMIC PREPARATIONS, MISCELLANEOUS	13	6	0	0	0	0	0	0	
Q6C	EYE VASOCONSTRICTORS (RX ONLY)	92	45	0	0	0	0	0	0	
Q6D	EYE VASOCONSTRICTORS (OTC ONLY)	80	73	0	0	0	0	0	0	
Q6E	EYE IRRIGATIONS	1	1	0	0	0	0	0	0	
Q6G	ALPHAGAN P/INTRAOC. PRESSURE REDUCERS	52,011	7,140	7,048	7,048	0	0	7,048	0	ED
Q6G	MIOTICS	52,011	7,140	4,035	4,035	0	0	4,035	0	ED
Q6H	EYE LOCAL ANESTHETICS	43	24	0	0	0	0	0	0	
Q6I	EYE ANTIBIOTIC-CORTICOID COMBINATIONS	6,375	4,393	0	0	0	0	0	0	
Q6J	MYDRIATICS	2,299	1,064	0	0	0	0	0	0	
Q6P	EYE ANTIINFLAMMATORY AGENTS	10,298	4,555	0	0	0	0	0	0	
Q6R	EYE ANTIHISTAMINES	8,061	4,183	4,035	4,035	0	0	4,035	0	ED
Q6S	EYE SULFONAMIDES	8,454	7,423	0	0	0	0	0	0	
Q6T	ARTIFICIAL TEARS	28,825	7,771	0	0	0	0	0	0	
Q6V	EYE ANTIVIRALS	140	97	0	0	0	0	0	0	
Q6W	OPHTHALMIC ANTIBIOTICS	37,145	27,297	4,035	4,035	0	0	4,035	0	ED
Q6Y	EYE PREPARATIONS, MISCELLANEOUS (OTC)	4,368	1,040	0	0	0	0	0	0	
Q7A	NOSE PREPARATIONS, MISCELLANEOUS (RX)	1,861	763	0	0	0	0	0	0	
Q7C	NOSE PREPARATIONS, VASOCONSTRICTORS (RX)	64	45	0	0	0	0	0	0	
Q7D	NOSE PREPARATIONS, VASOCONSTRICTORS (OTC)	1	1	0	0	0	0	0	0	
Q7E	NASAL ANTIHISTAMINE	3,518	1,843	0	0	0	0	0	0	
Q7H	NASAL MAST CELL STABILIZERS AGENTS	24	14	0	0	0	0	0	0	
Q7P	NASAL ANTI-INFLAMMATORY STEROIDS	64,916	26,490	12,769	12,769	0	0	12,769	0	ED
Q7W	NOSE PREPARATIONS ANTIBIOTICS	275	200	0	0	0	0	0	0	
Q7Y	NOSE PREPARATIONS, MISCELLANEOUS (OTC)	585	457	0	0	0	0	0	0	
Q8B	EAR PREPARATIONS, MISC. ANTI-INFECTIVES	2,186	1,719	0	0	0	0	0	0	
Q8F	CIPRO HC	4,694	3,917	7,048	7,048	0	0	7,048	0	ED
Q8H	EAR PREPARATIONS, LOCAL ANESTHETICS	8,157	7,525	0	0	0	0	0	0	

ATTACHMENT 3.2 --continued-- RetroDUR Exceptions & Interventions

IFIC TX CLASS	TARGET AHFS DESCRIPTION	RX COUNT	COUNT UNIQUE UTILIZERS	PATIENTS SCREENED	PATIENTS TARGETED	IBM INTERVENTIONS	TAI INTERVENTIONS[1]	TAI PDL TARGETED EDUCATION[2]	RetroDUR INTERVENTIONS	INTERVENTION TYPE
Q8R	EAR PREPARATIONS, EAR WAX REMOVERS	4,254	3,565	0	0	0	0	0	0	
Q8W	EAR PREPARATIONS, ANTIBIOTICS	18,680	14,983	4,035	4,035	0	0	4,035	0	ED
Q9B	BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS	22,109	3,341	12,769	12,769	0	0	12,789	0	ED
R1A	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE	83,210	12,777	4,053	4,053	0	0	4,053	0	ED
R1B	OSMOTIC DIURETICS	3	3	0	0	0	0	0	0	
R1E	CARBONIC ANHYDRASE INHIBITORS	3,378	669	0	0	0	0	0	0	
R1F	THIAZIDE AND RELATED DIURETICS	71,220	14,259	0	0	0	0	0	0	
R1H	POTASSIUM SPARING DIURETICS	35,045	6,353	0	0	0	0	0	0	
R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	49,902	8,619	0	0	0	0	0	0	
R1M	LOOP DIURETICS	269,719	40,548	1,594	1,594	0	0	1,594	0	ED
R1R	URICOSURIC AGENTS	694	124	0	0	0	0	0	0	
R1S	URINARY PH MODIFIERS	2,585	426	0	0	0	0	0	0	
R3U	URINE GLUCOSE TEST AIDS	9	6	0	0	0	0	0	0	
R3V	URINE TEST AIDS, MISCELLANEOUS	6	6	0	0	0	0	0	0	
R3W	URINE ACETONE TEST AIDS	359	276	0	0	0	0	0	0	
R3Y	URINE MULTIPLE TEST AIDS	16	11	0	0	0	0	0	0	
R3Z	URINE GLUCOSE/ACETONE TEST AIDS, STRIPS	62	38	0	0	0	0	0	0	
R4A	KIDNEY STONE AGENTS	49	5	0	0	0	0	0	0	
R5A	URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)	7,619	5,751	0	0	0	0	0	0	
R5B	URINARY TRACT ANALGESIC AGENTS	469	114	0	0	0	0	0	0	
S2A	COLCHICINE	4,646	1,131	0	0	0	0	0	0	
S2B	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE	310,739	96,273	0	0	0	0	0	0	
S2C	GOLD SALTS	85	13	0	0	0	0	0	0	
S2H	ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.	88	65	0	0	0	0	0	0	
S2I	ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR	1,623	264	0	0	0	0	0	0	
S2J	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	1,730	344	0	0	0	0	0	0	
S2M	ANTI-FLAM. INTERLEUKIN-1 RECEPTOR ANTAG.	117	26	0	0	0	0	0	0	
S2N	ANTI-ARTHRITIC, FOLATE ANTAG. AGENTS	54	10	0	0	0	0	0	0	
S7A	NEUROMUSCULAR BLOCKING AGENTS	125	73	0	0	0	0	0	0	
U6A	PHARMACEUTICAL ADJUVANTS, TABLETING	739	104	0	0	0	0	0	0	
U6C	THICKENING AGENTS, ORAL	45	16	0	0	0	0	0	0	
U6E	OINTMENT/CREAM BASES	371	195	0	0	0	0	0	0	
U6F	HYDROPHILIC CREAM/OINTMENT BASES	678	243	0	0	0	0	0	0	
U6H	SOLVENTS	6,737	2,334	0	0	0	0	0	0	
U6N	VEHICLES	31,567	5,810	0	0	0	0	0	0	
U6W	BULK CHEMICALS	3,712	1,313	0	0	0	0	0	0	
U7A	SUSPENDING AGENTS	57	23	0	0	0	0	0	0	
U7K	FLAVORING AGENTS	15	10	0	0	0	0	0	0	
U7N	SWEETENERS	99	40	0	0	0	0	0	0	
V1A	ALKYLATING AGENTS	1,713	354	0	0	0	0	0	0	
V1B	ANTIMETABOLITES	8,403	1,422	0	0	0	0	0	0	
V1C	VINCA ALKALOIDS	35	13	0	0	0	0	0	0	
V1D	ANTIBIOTIC ANTINEOPLASTICS	9	7	0	0	0	0	0	0	
V1E	STEROID ANTINEOPLASTICS	12,778	3,212	0	0	0	0	0	0	
V1F	ANTINEOPLASTICS, MISCELLANEOUS	2,483	416	0	0	0	0	0	0	
V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	622	126	0	0	0	0	0	0	
V1J	ANTIANDROGENIC AGENTS	584	107	0	0	0	0	0	0	
V1K	ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES	2	1	0	0	0	0	0	0	
V1N	SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)	13	2	0	0	0	0	0	0	
V1O	ANTINEOPLASTIC LHRH AGONIST, PITUITARY SUPPR.	186	65	0	0	0	0	0	0	
V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	352	72	0	0	0	0	0	0	
V1T	SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERM)	7,187	969	0	0	0	0	0	0	
W1A	PENICILLINS	282,939	165,220	0	0	0	0	0	0	
W1B	CEPHALOSPORINS	16	7	0	0	0	0	0	0	
W1C	TETRACYCLINES	33,264	17,050	0	0	0	0	0	0	
W1D	MACROLIDES	148,861	98,787	4,685	4,685	0	0	4,685	0	ED
W1F	AMINOGLYCOSIDES	3,827	1,239	0	0	0	0	0	0	
W1G	ANTITUBERCULAR ANTIBIOTICS	838	527	0	0	0	0	0	0	
W1J	VANCOMYCIN AND DERIVATIVES	4,905	1,151	0	0	0	0	0	0	
W1K	LINCOSAMIDES	10,404	7,598	0	0	0	0	0	0	

ATTACHMENT 3.2 --continued-- RetroDUR Exceptions & Interventions

IFIC TX CLASS	TARGET AHFS DESCRIPTION	RX COUNT	COUNT UNIQUE UTILIZERS	PATIENTS SCREENED	PATIENTS TARGETED	IBM INTERVENTIONS	TAI INTERVENTIONS[1]	TAI PDL TARGETED EDUCATION[2]	RetroDUR INTERVENTIONS	INTERVENTION TYPE
W1L	ANTIBIOTICS, MISCELLANEOUS, OTHER	11	7	0	0	0	0	0	0	
W1M	STREPTOGRAMINS	23	4	0	0	0	0	0	0	
W1N	POLYMYXIN AND DERIVATIVES	108	34	0	0	0	0	0	0	
W1O	OXAZOLIDINONES	425	239	0	0	0	0	0	0	
W1P	BETALACTAMS	106	41	0	0	0	0	0	0	
W1Q	CIPRO XL	98,057	49,633	115	97	0	0	0	0	OU
W1Q	FLUOROQUINOLONES	98,057	49,633	4,685	4,685	0	0	4,685	0	ED
W1S	CARBAPENEMS (THIENAMYCINS)	784	196	0	0	0	0	0	0	
W1W	CEPHALOSPORINS - 1ST GENERATION	91,867	62,222	0	0	0	0	0	0	
W1X	CEPHALOSPORINS - 2ND GENERATION	29,453	21,991	0	0	0	0	0	0	
W1Y	CEPHALOSPORINS - 3RD GENERATION	39,658	26,607	4,685	4,685	0	0	4,685	0	ED
W1Z	CEPHALOSPORINS - 4TH GENERATION	449	123	0	0	0	0	0	0	
W2A	ABSORBABLE SULFONAMIDES	56,720	31,696	0	0	0	0	0	0	
W2E	ANTI-MYCOBACTERIUM AGENTS	1,516	358	0	0	0	0	0	0	
W2F	NITROFURAN DERIVATIVES	26,284	13,197	0	0	0	0	0	0	
W2G	CHEMOTHERAPEUTICS, ANTIBACTERIAL, MISC.	2,644	735	0	0	0	0	0	0	
W2Y	ANTI-INFECTIVES, MISC. (ANTIBACTERIALS)	1	1	0	0	0	0	0	0	
W3A	ANTIFUNGAL ANTIBIOTICS	18,538	12,779	4,685	4,685	0	0	4,685	0	ED
W3B	ANTIFUNGAL AGENTS	35,918	20,187	7,048	7,048	0	0	7,048	0	ED
W4A	ANTIMALARIAL DRUGS	23,549	4,805	0	0	0	0	0	0	
W4C	AMEBACIDES	5	4	0	0	0	0	0	0	
W4E	ANAEROBIC ANTIPROTOZOAL-ANTIBACT.AGENTS	16,891	13,162	0	0	0	0	0	0	
W4K	ANTIPROTOZOAL DRUGS, MISCELLANEOUS	145	38	0	0	0	0	0	0	
W4L	ANTHELMINTICS	2,433	2,088	0	0	0	0	0	0	
W4M	ANTIPARASITICS	11	6	0	0	0	0	0	0	
W4P	ANTILEPROTICS	1,024	234	0	0	0	0	0	0	
W5A	ANTIVIRAL ANTIHERPETIC	15,409	7,801	7,048	7,048	0	0	7,048	0	ED
W5A	ANTIVIRALS, INFLUENZA	15,409	7,801	7,048	7,048	0	0	7,048	0	ED
W5C	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	2,338	305	0	0	0	0	0	0	
W5D	ANTIVIRAL MONOCLONAL ANTIBODIES	1,521	329	0	0	0	0	0	0	
W5F	HEPATITIS B TREATMENT AGENTS	187	34	0	0	0	0	0	0	
W5G	HEPATITIS C TREATMENT AGENTS	2,956	414	0	0	0	0	0	0	
W5I	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	1,499	290	0	0	0	0	0	0	
W5J	ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI	6,963	619	0	0	0	0	0	0	
W5K	ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI	3,245	500	0	0	0	0	0	0	
W5L	ANTIVIRALS, HIV-SPECIFIC, NUCLEO. ALG, RTI COMB	2,750	456	0	0	0	0	0	0	
W5M	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIB.COMB	1,448	267	0	0	0	0	0	0	
W5N	ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS	41	18	0	0	0	0	0	0	
W7B	VIRAL/TUMORIGENIC VACCINES	503	339	0	0	0	0	0	0	
W7C	INFLUENZA VIRUS VACCINES	8,389	8,231	0	0	0	0	0	0	
W7H	ENTERIC VIRUS VACCINES	1	1	0	0	0	0	0	0	
W7J	NEUROTOXIC VIRUS VACCINES	2	2	0	0	0	0	0	0	
W7K	ANTISERA	336	153	0	0	0	0	0	0	
W7L	GRAM POSITIVE COCCI VACCINES	1,575	1,522	0	0	0	0	0	0	
W7M	GRAM (-) BACILLI (NON-ENTERIC) VACCINES	2	2	0	0	0	0	0	0	
W7N	TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS	60	58	0	0	0	0	0	0	
W7Q	GRAM NEGATIVE COCCI VACCINES	9	9	0	0	0	0	0	0	
W7T	ANTIGENIC SKIN TESTS	444	428	0	0	0	0	0	0	
W7Z	VACCINE/TOXOID PREPARATIONS, COMBINATIONS	93	88	0	0	0	0	0	0	
W8D	OXIDIZING AGENTS	396	136	0	0	0	0	0	0	
W8E	ANTISEPTICS, GENERAL	8,827	3,651	0	0	0	0	0	0	
W8F	IRRIGANTS	25,382	5,191	0	0	0	0	0	0	
W8G	ANTISEPTICS, MISCELLANEOUS	17	14	0	0	0	0	0	0	
W8H	MOUTHWASHES	1	1	0	0	0	0	0	0	
W8J	ANTIBACTERIAL AGENTS, MISCELLANEOUS	20	3	0	0	0	0	0	0	
W8T	PRESERVATIVES	53	46	0	0	0	0	0	0	
X0A	BLOOD TESTING PREPARATIONS, IN-VITRO	2	1	0	0	0	0	0	0	
X1A	CONDOMS	7	4	0	0	0	0	0	0	
X1B	DIAPHRAGMS/CERVICAL CAP	19	19	0	0	0	0	0	0	
X1C	INTRA-UTERINE DEVICES (IUD'S)	9	9	0	0	0	0	0	0	
X2A	NEEDLES/NEEDLELESS DEVICES	3,033	1,308	0	0	0	0	0	0	
X2B	SYRINGES AND ACCESSORIES	22,259	8,567	0	0	0	0	0	0	

– continued --ATTACHMENT 3.2 RetroDUR Exceptions & Interventions

IFIC TX CLASS	TARGET AHFS DESCRIPTION	RX COUNT	COUNT UNIQUE UTILIZERS	PATIENTS SCREENED	PATIENTS TARGETED	IBM INTERVENTIONS	TAI INTERVENTIONS[1]	TAI PDL TARGETED EDUCATION[2]	RetroDUR INTERVENTIONS	INTERVENTION TYPE
X3A	OSTOMY SUPPLIES	3,211	419	0	0	0	0	0	0	
X4B	INCONTINENCE SUPPLIES	3,683	768	0	0	0	0	0	0	
X5A	MEDICAL SUPPLIES, MISCELLANEOUS	254	85	0	0	0	0	0	0	
X5B	BANDAGES AND RELATED SUPPLIES	6,049	1,360	0	0	0	0	0	0	
X5D	GLOVES	25	21	0	0	0	0	0	0	
X6A	MEDICAL SUPPLIES, MISCELLANEOUS (GROUP 2)	54	21	0	0	0	0	0	0	
X7A	CONTACT LENS PREPARATIONS (GAS, HARD, SOFT)	2	2	0	0	0	0	0	0	
X8A	PARENTERAL ADMINISTRATION SETS	453	81	0	0	0	0	0	0	
X8B	BLOOD ADMINISTRATION SETS	1	1	0	0	0	0	0	0	
X8C	IRRIGATION ADMINISTRATION SETS	33	14	0	0	0	0	0	0	
Y0A	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS	899	638	0	0	0	0	0	0	
Y0B	CRUTCHES	31	31	0	0	0	0	0	0	
Y0E	SEXUAL DYSFUNCTION DEVICES	2	2	0	0	0	0	0	0	
Y1A	FEEDING DEVICES	52	17	0	0	0	0	0	0	
Y1B	THERMOMETERS	8	8	0	0	0	0	0	0	
Y2G	CLEAN AIR CENTERS	4	4	0	0	0	0	0	0	
Y3A	DURABLE MEDICAL EQUIPMENT, MISC (GROUP 1)	13,376	7,209	0	0	0	0	0	0	
Y3C	DURABLE MEDICAL EQUIPMENT, MISC (GROUP 2)	199	193	0	0	0	0	0	0	
Y4B	CATHETERS AND RELATED DEVICES	1,001	227	0	0	0	0	0	0	
Y5A	BRACES AND RELATED DEVICES	224	198	0	0	0	0	0	0	
Y5C	HOT WATER BOTTLE AND RELATED D EVICES	8	8	0	0	0	0	0	0	
Y7A	RESPIRATORY AIDS, DEVICES, EQUIPMENT	6,190	5,326	0	0	0	0	0	0	
Y8A	HEARING AIDS AND RELATED DEVICES	52	28	0	0	0	0	0	0	
Y8B	RUBBER SYRINGES	2	2	0	0	0	0	0	0	
Y9A	DIABETIC SUPPLIES	2,926	2,608	0	0	0	0	0	0	
Z2A	ANTIHISTAMINES	360,462	115,217	1,695	1,695	0	0	1,695	0	ED
Z2E	IMMUNOSUPPRESSIVES	17,140	1,501	0	0	0	0	0	0	
Z2F	MAST CELL STABILIZERS	4,529	1,679	4,035	4,035	0	0	4,035	0	ED
Z2G	IMMUNOMODULATORS	3,246	1,568	0	0	0	0	0	0	
Z2H	SYSTEMIC ENZYME INHIBITORS	120	11	0	0	0	0	0	0	
Z2L	MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)	8	6	0	0	0	0	0	0	
Z3G	MISCELLANEOUS AGENTS	14	5	0	0	0	0	0	0	
Z4B	LEUKOTRIENE RECEPTOR ANTAG.	75,606	17,278	872	764	0	0	0	495	U U
Z4B	LEUKOTRIENE RECEPTOR ANTAG.	75,606	17,278	12,769	12,769	0	0	12,769	0	ED
Z9A	UNCLASSIFIED DRUGS	20	14	0	0	0	0	0	0	

1. TAI interventions referred to face-to-face, one-on-one meetings with prescribers.
2. TAI PDL targeted education occurred in large open invitation “town hall” type group meetings. Numbers reflect total patients in targeted area were physicians were invited.

ATTACHMENT 3.3

RETRODUR INTERVENTIONS BY PROGRAM TYPE

YEAR-END SUMMARY OF RETRODUR INTERVENTIONS								
MONTH / YEAR	NAME OF INITIATIVE	Program Type	PROBLEM TYPE	Rx Count	# PTS REVIEWED	% Screen / # Rxs	# PTS INTERVENED	# PRESCRIBERS TARGETED
Oct-02	PDL ACEI ED	IBM	PDL ED	263,035	1,610	0.6%	1,586	685
Nov-02	PDL THIAZOLIDINEDIONES ED	IBM	PDL ED	68,672	1,514	2.2%	1,470	736
Dec-02	PDL ARB ED	IBM	PDL ED	71,691	1,739	2.4%	1,686	912
Jan-03	PDL SERMS	IBM	PDL ED	99,475	1,313		1,302	588
Feb-03	PDL SERMS	IBM	PDL ED		1,516	2.8%	0	644
Mar-03	NO INTERVENTION APPROVED	IBM			0		0	0
Apr-03	NO INTERVENTION APPROVED	IBM			0		0	0
May-03	NO INTERVENTION APPROVED	IBM			0		0	0
Jun-03	NO INTERVENTION APPROVED	IBM			0		0	0
Jul-03	DOSE OP SSRIs	IBM	Therapeutic Appropriateness	465,064	1,072	0.2%	1,058	759
Aug-03	NO INTERVENTION APPROVED	IBM			0		0	0
Sep-03	HIGH UTILIZER	IBM	Overuse (OU)	1,146,254	4,377	0.4%	501	756
TOTALS				2,114,191	13,141	0.6%	7,603	5,080
MONTH / YEAR	NAME OF INITIATIVE	Program Type	PROBLEM TYPE	Rx Count	# PTS REVIEWED	% Screen / # Rxs	# PTS INTERVENED	# PRESCRIBERS TARGETED
Oct-02	PDL EDUCATION	TAI	PDL ED		1,695		1,695	337
Nov-02	NO INTERVENTION APPROVED	TAI			0		0	0
Dec-02	PDL EDUCATION	TAI	PDL ED		1,594		1,594	302
Jan-03	NO INTERVENTION APPROVED	TAI			0		0	0
Feb-03	PDL EDUCATION	TAI	PDL ED		12,769		12,769	652
Mar-03	PDL EDUCATION	TAI	PDL ED		4,685		4,685	505
Apr-03	PDL EDUCATION	TAI	PDL ED		4,053		4,053	510
May-03	PDL EDUCATION	TAI	PDL ED		4,035		4,035	509
Jun-03	PDL EDUCATION	TAI	PDL ED		7,048		7,106	725
Jul-03	DOSE OP SSRIs	TAI	Therapeutic Appropriateness	465,064	188	0.04%	189	30
Aug-03	DOSE OP SSRIs	TAI	Therapeutic Appropriateness		101		103	24
Sep-03	HIGH UTILIZER PDL ED	TAI	PDL ED	1,146,254	488	0.0%	488	60
TOTALS				1,611,318	36,656	2.3%	36,717	3,654
MONTH / YEAR	NAME OF INITIATIVE	Program Type	PROBLEM TYPE	Rx Count	# PTS REVIEWED	% Screen / # Rxs	# PTS INTERVENED	# PRESCRIBERS TARGETED
Oct-02	NO INTERVENTION APPROVED	RetroDUR			0		0	0
Nov-02	NO INTERVENTION APPROVED	RetroDUR			0		0	0
Dec-02	NO INTERVENTION APPROVED	RetroDUR			0		0	0
Jan-03	ALBUTEROL OVERUSE ASTHMA	RetroDUR	Overuse (OU)	281,474	862	0.3%	764	495
Feb-03	NO INTERVENTION APPROVED	RetroDUR			0		0	0
Mar-03	NO INTERVENTION APPROVED	RetroDUR			0		0	0
Apr-03	NO INTERVENTION APPROVED	RetroDUR			0		0	0
May-03	NO INTERVENTION APPROVED	RetroDUR			0		0	0
Jun-03	NO INTERVENTION APPROVED	RetroDUR			0		0	0
Jul-03	NO INTERVENTION APPROVED	RetroDUR			0		0	0
Aug-03	NO INTERVENTION APPROVED	RetroDUR			0		0	0
Sep-03	LIPOTROPIC DOSE OP	RetroDUR	Therapeutic Appropriateness	257,682	19,741	7.7%	247	226
TOTALS				539,156	20,603	3.8%	1,011	721
	ANNUAL SUMMARY RETRODUR INTERVENTIONS			Rx Count	# PTS REVIEWED	% Screen / # Rxs	# PTS INTERVENED	# PRESCRIBERS TARGETED
				4,264,665	70,400	1.7%	45,331	9,455

ATTACHMENT 3.4

RETRODUR INTERVENTIONS BY PROBLEM CATEGORY

Year-End Summary RetroDUR Interventions by Problem Category

Intervention Type	Intervention Description	# Recipients Intervened By Problem Category			
		OU	ED*	TA	TOTALS
Standard RetroDUR	Letter Mailing	764	0	247	1,011
TAI PDL TARGETED EDUCATION*	Academic Detailing		35,879 *	292	36,171*
TAI	Academic Detailing		777		777
IBM	Phone Calls	501	6,044	1,058	7,603
TOTALS		**1,265**	**42,700**	**1,597**	**45,562**

Problem Category Key	
Over-Utilization	OU
Preferred Drug List Education*	ED
Therapeutic Appropriateness (Dose Optimization)	TA

* Involved large group prescriber meetings affecting all patients on non-PDL drugs.

Numbers reflect the patients affected.

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 3.5 Details of RetroDUR Interventions Performed

The following information is a year-end analysis of RetroDUR activities that were approved by the DUR Board and performed by ACS though the following RetroDUR program types: standard RetroDUR programs, IBM and TAI.

(Note: Not all RetroDUR criteria and initiatives include cost savings. Quality of care initiatives may actually increase pharmacy costs, while reducing the use of other resources and improving the quality of life of the participant).

Intensified Benefits Management Program

By contacting prescribers throughout the implementation of the Preferred Drug List (PDL), the IBM program was able to provide advance notice of a change to the Medicaid program and allowed individualized program education regarding the PDL.

IBM SUMMARY

- Estimated Savings per utilizer per year for all interventions months were $2,048.64
- Annual Estimated Cost Savings for the IBM Program for FFY 2003 were $1,211,025.36.

OCTOBER 2002 IBM — Non-PDL Angiotensin Converting Enzyme Inhibitors (ACEIs)

Purpose of Initiative:

The purpose of this initiative was to educate prescribers on the PDL ACEIs: captopril (for patients ≤12 years), enalapril, lisinopril, Lotensin, Mavik and Monopril.

Methodology:

During October 2002, IBM pharmacists reviewed the medication profiles of 1610 patients who had received a non-PDL ACEIs during the month of August and contacted the prescribers by phone.

Intervention Goal:

The goal was to facilitate the conversion of patients from a non-PDL to a PDL ACEIs.

Intervention Results:

Of the 1610 patients targeted, 1586 were intervened upon through calls to 685 prescribers. A total of 67 patients were identified with incorrect prescriber information, 14 patients had the ACEI discontinued and 1097 patients were converted to a PDL agent. Prescribers for 79 patients refused a change and received PA for the non-PDL agent, 7 patients were deceased, and prescribers for 322 patients stated they would consider a PDL switch. Three months after the intervention, there were only 110 patients still receiving a non-PDL ACEI. A total of 1469 patients were converted to the PDL agent.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

Cost Savings Analysis:
The PUPM in the control group increased $2.88 while the PUPM in the targeted group decreased $6.64, for a net PUPM savings of $9.52.

NOVEMBER 2002 IBM — Non-PDL Thiazolidinediones

Purpose of Initiative:
The purpose of this initiative was to educate prescribers on the PDL thiazolidinediones: Actos 15mg, Avandia 4mg and Avandia 8mg.

Methodology:
IBM pharmacists reviewed medication profiles of 1514 patients who had a claim for a non-PDL thiazolidinedione during the months of August and September 2002. The prescribers for these patients were contacted by phone during November 2002.

Intervention Goal:
The goal was to facilitate the conversion of patients from a non-PDL to a PDL thiazolidinedione.

Intervention Results:
There were 1514 patient profiles reviewed. Of the 1470 patients intervened upon, prescribers for 1289 patients stated they would consider changing their patients to the PDL agents, 32 patients had the incorrect prescriber, 3 patients were deceased, 83 prescribers were unavailable, 2 prescribers discontinued the non-PDL agents and 61 were non-responsive. Of the 1470 patients who were targeted for a changed to the PDL agents, 1222 had a claim for the PDL agent within the following 180 days.

Cost Savings Analysis:
The targeted patients had a decrease of 63.47% in the dollars spent PUPM in the 90-day period following the intervention compared to the 90-day period prior to the intervention. The PUPM in the control group decreased $64.58 while the PUPM in the targeted group decreased $82.09, for a net PUPM savings of $17.51.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

DECEMBER 2002 IBM — Non-PDL Angiotensin Receptor Blockers (ARBs)

Purpose of Initiative:

The purpose of this initiative was to educate prescribers about the PDL ARBs:Cozaar and Micardis.

Methodology:

IBM pharmacists reviewed the medication profiles of 1739 patients who had a claim for a non-PDL ARBs month of October 2002. The prescribers for these patients were contacted by phone during December 2002.

Intervention Goal:

The goal was to facilitate the conversion of patients from a non-PDL to a PDL ARB.

Intervention Results:

Of the 1739 patients targeted, 1686 were intervened upon through calls to 912 prescribers. A total of 89 patients were identified with incorrect prescriber information, 14 patients had the ARB discontinued and 1155 patients were converted to a PDL agent. Prescribers for 359 patients refused a change and received prior authorization for the non-PDL agent, 5 patients were deceased and prescribers for 64 patients stated they would consider a PDL switch.

Cost Savings Analysis:

Targeted patients had a decrease of 56.62% in the dollars spent on the non-PDL agents PUPM in the 90-day period following the intervention compared to the 90-day period prior to the intervention. Comparing the target to the control, there was a net decrease of 2.49% in the PUPM for the target group. The PUPM in the control group decreased $17.67 while the PUPM in the targeted group decreased $23.63, for a net PUPM savings of $5.96.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

JANUARY 2003 IBM — Non-PDL Selective Estrogen Receptor Modulators (SERM)/Bone Resorption Agents

Purpose of Initiative:

The purpose of this initiative was to educate prescribers on the PDL SERM/Bone Resorption Agents: Actonel (all formulations), Fosamax (weekly formulations), Evista and etidronate disodium (generic products).

Methodology:

IBM pharmacists reviewed the medication profiles of 1313 patients who had a claim for a non-PDL SERM/Bone Resorption Agent during the month of November 2002. The prescribers for these patients were contacted by phone during the month of January 2003.

Intervention Goal:

The goal was to facilitate the conversion of patients from a non-PDL to a PDL SERM/Bone Resorption Agent.

Intervention Results:

Of the 1313 patients targeted, 1302 were intervened upon through calls to 588 prescribers. A total of 67 patients were identified with incorrect prescriber information, 1 patient had the SERM discontinued and 703 patients were converted to a PDL agent. Prescribers for 587 patients refused a change and received prior authorization for the non-PDL agent, 11 patients were deceased.

Cost Savings Analysis:

Targeted patients had a decrease of 44.61% in the dollars spent on the non-PDL agents PUPM in the 90-day period following the intervention compared to the 90-day period prior to the intervention. Comparing the target to the control, there was a net increase of 5.35% in the PUPM for the target group. The PUPM in the control group decreased $23.46 while the PUPM in the targeted group decreased $20.73, for a net PUPM change of -$2.73 PUPM. This initiative cost 7.4% more for the PDL agents PUPM over the non-PDL agents. This initiative is expected to project a cost savings when rebates are factored in and the generics are released in this class.

FEBRUARY 2003 IBM — Non-PDL SERM/Bone Resorption Agents Continued

Purpose of Initiative and Intervention Goal: Same as Jan 2003

Methodology: IBM pharmacists reviewed the medication profiles of 1604 patients who had a claim for a non-PDL SERM/Bone Resorption Agent during the month of November 2002. The prescribers for these patients were contacted by phone during Feb 2003.

Intervention Results: Discontinued after one week, at the request of the client.

Cost Savings Analysis: None

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

JULY 2003 IBM — Dose Optimization of Selective Serotonin Reuptake Inhibitors (SSRIs)

Purpose of Initiative:
The purpose of this initiative was to educate prescribers about dose optimization of SSRIs.

Methodology:
IBM pharmacists reviewed medication profiles of 1072 patients who had a claim for twice daily dosing of an SSRI from April 2003 to June 2003. Prescribers were contacted by phone in July 2003 and asked to review their patients' medication profiles to determine the need for twice daily dosing.

Intervention Goal:
The goal of this intervention was to facilitate the conversion of patients currently receiving lower doses of SSRIs twice daily to the higher dose once daily in an effort to reduce costs and improve patient compliance.

Intervention Results:
Of the 1072 patients targeted, 1058 were intervened upon through calls to 759 prescribers. A total of 102 patients were identified with incorrect prescriber information, 16 patients had the SSRI discontinued and 669 patients were converted to the once daily dosing. Prescribers for 195 patients did not make any changes, prescribers for 66 patients would consider a change in the future and 10 patients were deceased.

Cost Savings Analysis:
There was a 9.74% decrease PUPM in the target group compared to a 10.62% decrease in the control group. The PUPM in the control group decreased $13.18 while the PUPM in the target group decreased $9.07, for a net PUPM change of -$4.11. This initiative is expected to project a cost savings when rebates are factored in and the generics are released in this class.

SEPTEMBER 2003 IBM — High Utilizers and PDL Education

Purpose of Initiative:
The purpose of this initiative was to educate prescribers on the following issues: drug dosing, duplicate therapies, over-utilization, PDL and inappropriate drug therapy.

Methodology:
IBM pharmacists reviewed medication profiles of 501 patients who received greater than 20 medications during the month of July 2003. The prescribers for these patients were contacted by phone during the month of September 2003 to discuss one or more of the following issues: drug dosing, duplicate therapies, over-utilization, PDL, and inappropriate drug therapy. If a patient had multiple prescribers, phone calls were made to each prescriber.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

Intervention Goal:

The goal was to coordinate appropriate care and decrease costs.

Intervention Results:

There were 4,377 patient profiles review and 507 selected as high utilizers. There were 15 prescribers incorrectly identified, 355 patients had therapy modified prior to contact, 43 patients had no changes made and 2 had medications discontinued. Prescribers for 31 patients accepted recommendations and 2 patients were deceased. Prescribers for 53 patients took recommendations under advisement. The average number of prescriptions per utilizer decreased by 6 in the target group.

Cost Savings Analysis:

Targeted patients had a decrease of 24.77% in the dollars spent in the 90-day period following the intervention compared to the 90-day period prior to the intervention. The PUPM in the control group decreased $153.49 while the PUPM in the targeted group decreased $298.06, for a net PUPM savings of $144.57.

Therapeutic Academic Intervention (TAI) Program

By contacting prescribers throughout the implementation of the PDL, the TAI program was able to provide education regarding the PDL.

TAI SUMMARY

- Estimated Savings per utilizer per year for all interventions months was $2,055.48.
- Annual Estimated Cost Savings for the TAI Program for FFY 2003 was $1,038,216.96.

OCTOBER 2002 TAI — PDL Education

Purpose of Initiative:

In an effort to combat the rising costs of drug therapy, Indiana Medicaid implemented a Preferred Drug List (PDL) throughout FFY 2003. During the month of October 2002, the TAI pharmacist visited various large practices and hospital settings to educate prescribers about the PDL.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

Methodology:
The TAI pharmacist scheduled face-to-face meetings with various group practices throughout the state to provide education concerning the implementation of the PDL. The TAI pharmacist provided prescribers with the most recent PDL list and provider bulletins for reference. He educated prescribers and their staff members about the procedures for requesting non-PDL medications.

Intervention Goal:
The goal was to facilitate the conversion of patients from a non-PDL to PDL drugs and to provide educational materials to prescribers.

Intervention Results:
The group meetings with physicians were very positive. The physicians were interested in the new PDL and had several questions concerning the drugs that had been reviewed. Prior to the intervention, 74% of claim dollars in the targeted group were for non-PDL agents compared to 36% of claim dollars three months post intervention. Prior to the intervention, 54.59% of prescribers in the targeted group were using PDL agents; three months post intervention 68.11% of prescribers were prescribing for PDL agents.

Cost Savings Analysis:
The PUPM in the control group for all non-PDL agents increased $40.16. The PUPM in the target group increased $38.27 for a net PUPM savings in the target group of $1.89.

DECEMBER 2002 TAI — PDL Education

Purpose of Initiative:
The purpose of this initiative was to educate prescribers about the PDL by visiting large practices and hospital settings.

Methodology:
The TAI pharmacist scheduled face-to-face meetings with various group practices throughout the state to provide education concerning the implementation of the PDL. The TAI pharmacist provided prescribers with the most recent PDL list and provider bulletins for reference. He educated prescribers and their staff members about the procedures for requesting non-PDL medications.

Intervention Goal:
The goal was to facilitate the conversion of patients from a non-PDL to PDL drugs and to provide educational materials to prescribers.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

Intervention Results:
The group meetings with physicians were very positive. The physicians were interested in the new Preferred Drug List and had several questions concerning the drugs that had been reviewed. There were questioned answered about the TCP desk and prior authorization. Prior to this intervention, 644 patients were on non-PDL agents and after the intervention there were 51.

Cost Savings Analysis:
The PUPM in the control group for all non-PDL agents increased $8.70. The PUPM in the target group increased $2.12 for a net PUPM savings of $6.58.

FEBRUARY 2003 TAI — PDL Education

Purpose of Initiative:
The purpose of this initiative was to educate prescribers about the PDL by visiting large practices and hospital settings.

Methodology:
The medication profiles of patients who had pharmacy claims paid in December 2002 were screened. Group meetings were conducted with physicians, physician assistants, nurse practitioners and office managers to educate them on the PDL. Pharmacy claims data was screened for the 90-day period prior to the month of February and the 90-day period following February to assess changes in prescribing habits.

Intervention Goal:
The goal was to facilitate the conversion of patients from a non-PDL to PDL drugs.

Intervention Results:
There were 12,769 patients screened and 652 prescribers targeted. There was a 6.16% decrease in the number of claims for non-PDL medications in the targeted patients after the intervention and a 26.68% decrease in the dollars paid. The PUPM decreased by 22.99% compared to a decrease in the PUPM in the control group of 20.01%.

Cost Savings Analysis:
The PUPM in the control group for all non-PDL agents decreased $5.92. The PUPM in the target group decreased $5.94 for a net PUPM savings of $0.02.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

MARCH 2003 TAI — PDL Education

Purpose of Initiative:
The purpose of this initiative was to educate prescribers about the PDL by visiting large practices and hospital settings.

Methodology:
The medication profiles of patients who had pharmacy claims paid in January 2003 were screened. Group meetings were conducted with physicians, physician assistants, nurse practitioners and office managers to educate them on the PDL. Pharmacy claims data was screened for the 90-day period prior to the month of March and the 90-day period following March to assess changes in prescribing habits.

Intervention Goal:
The goal was to facilitate the conversion of patients from a non-PDL to PDL drugs.

Intervention Results:
There were 4,685 patients screened and 505 prescribers targeted. There was an 1.05% decrease in the number of claims for non-PDL medications in the targeted patients after the intervention and a 15.91% decrease in the dollars paid. The PUPM decreased by 11.84% compared to a decrease in the PUPM in the non-targeted control group of 10.03%.

Cost Savings Analysis:
The PUPM in the control group for all non-PDL agents decreased $2.62. The PUPM in the target group decreased $3.03 for a net PUPM savings of $0.41.

APRIL 2003 TAI — PDL Education

Purpose of Initiative:
The purpose of this initiative was to educate prescribers about the PDL by visiting large practices and hospital settings.

Methodology:
The medication profiles of patients who had pharmacy claims paid in February 2003 were screened. Group meetings were conducted with physicians, physician assistants, nurse practitioners and office managers to educate them on the PDL. Pharmacy claims data was screened for the 90-day period prior to the month of April and the 90-day period following April to assess changes in prescribing habits.

Intervention Goal:
The goal was to facilitate the conversion of patients from a non-PDL medication to PDL medications.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

Intervention Results:
There were 4053 patients screened and 510 prescribers targeted. There was a 2.02% decrease in the number of claims for non-PDL medications in the targeted patients after the intervention and a 7.77% decrease in the dollars paid. The PUPM decreased by 9.32% compared to a decrease in the PUPM in the control group of 5.48%.

Cost Savings Analysis:
The PUPM in the control group for all non-PDL agents decreased $1.29. The PUPM in the target group decreased $2.26 for a net PUPM savings of $0.97.

MAY 2003 TAI — PDL Education

Purpose of Initiative:
The purpose of this initiative was to educate prescribers about the PDL by visiting large practices and hospital settings.

Methodology:
The medication profiles of patients who had pharmacy claims paid in March 2003 were screened. Group meetings were conducted with physicians, physician assistants, nurse practitioners and office managers to educate them on the PDL. Pharmacy claims data was screened for the 90-day period prior to the month of May and the 90-day period following May to assess changes in prescribing habits.

Intervention Goal:
The goal was to facilitate the conversion of patients from a non-PDL to PDL drugs.

Intervention Results:
There were 4035 patients screened and 509 prescribers targeted. There was 0.79% decrease in the number of claims for non-PDL medications in the targeted patients after the intervention and a 5.43% decrease in the dollars paid. The PUPM decreased by 5.57% compared to a decrease in the PUPM in the control group of 1.9%.

Cost Savings Analysis:
The PUPM in the control group for all non-PDL agents decreased $0.44. The PUPM in the target group decreased $1.28 for a net PUPM savings of $0.84.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

JUNE 2003 TAI — PDL Education

Purpose of Initiative:
The purpose of this initiative was to educate prescribers about the PDL by visiting large practices and hospital settings.

Methodology:
The medication profiles of patients who had pharmacy claims paid in April 2003 were screened. Group meetings were conducted with physicians, physician assistants, nurse practitioners and office managers to educate them on the PDL. Pharmacy claims data was screened for the 90-day period prior to the month of June and the 90-day period following June to assess changes in prescribing habits.

Intervention Goal:
The goal was to facilitate the conversion of patients from non-PDL to PDL drugs.

Intervention Results:
There were 7048 patients screened and 725 prescribers targeted. There was 1.35% decrease in the number of claims for non-PDL medications in the targeted patients after the intervention and a 5.57% decrease in the dollars paid. The PUPM decreased by 6.34% compared to a decrease in the PUPM in the control group of 3.97%.

Cost Savings Analysis:
The PUPM in the control group for all non-PDL agents decreased $1.30. The PUPM in the target group decreased $2.16 for a net PUPM savings of $0.86.

JULY 2003 TAI — Dose optimization of SSRIs

Purpose of Initiative:
The purpose of this initiative was to provide evaluation of prescribing patterns and subsequent prescriber education to improve the appropriateness and cost effectiveness of drug therapy for recipients on SSRIs.

Methodology:
The intervention criteria were based upon recipients who had received 60 units or more of a SSRI for a 30-day period. Prescribers were targeted for a face-to-face discussion based upon the number of patients within their practice meeting the above criteria. During the visit, the clinical pharmacist reviewed the SSRI dose optimization options available for their patients.

Intervention Goal:
The goal of this intervention was to convert patients from lower dose twice daily SSRIs to the higher dose once daily equivalent therapy.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

Intervention Results:

There were 188 patients screened and 30 prescribers targeted. Most of the physicians visited agreed to make an effort to adjust the doses of the prescribed SSRIs when deemed clinically appropriate. An analysis of prescribing patterns of those prescribers targeted showed a 5.85% decrease in the number of prescriptions for SSRIs with a resulting 9.22% decrease in the dollars paid. The PUPM decreased by 9.70% compared to a decrease in the PUPM in the control group of 7.08%.

Cost Savings Analysis:

The PUPM in the control group for all non-PDL agents decreased $6.02. The PUPM in the target group decreased $8.58 for a net PUPM savings of $2.56.

AUGUST 2003 TAI — Dose optimization of SSRIs Continued

Purpose of Initiative:

The purpose of this initiative was to provide evaluation of prescribing patterns and subsequent prescriber education to improve the appropriateness and cost effectiveness of drug therapy for recipients on SSRIs.

Methodology:

The intervention criteria were based upon recipients who had received 60 units or more of a SSRI for a 30-day period. Prescribers were targeted for a face-to-face discussion based upon the number of patients within their practice meeting the above criteria. During the visit, the clinical pharmacist reviewed the SSRI dose optimization options available for their patients. There were 103 patient profiles reviewed and 60 prescribers targeted.

Intervention Goal:

The goal of this intervention was to convert patients from lower dose twice daily SSRIs to the higher dose once daily equivalent therapy.

Intervention Results:

There were 101 patients screened and 24 prescribers targeted. Most of the physicians visited agreed to make an effort to adjust the doses of the prescribed SSRIs when deemed clinically appropriate. An analysis of prescribing patterns of those prescribers targeted showed a 6.29% decrease in the number of prescriptions for SSRIs with a resulting 15.95% decrease in the dollars paid. The PUPM decreased by 17.58% compared to a decrease in the PUPM in the non-targeted control group of 8.44%.

Cost Savings Analysis:

The PUPM in the control group for all non-PDL agents decreased $4.45. The PUPM in the target group decreased $10.56 for a net PUPM savings of $6.11.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

SEPTEMBER 2003 TAI INTERVENTION — High Utilizers PDL Education

Purpose of Initiative:

The purpose of this initiative was to eliminate therapeutic duplication and over utilization. In addition, the initiative also educated prescribers on the PDL.

Methodology:

The selection criteria were based upon recipients who had been receiving greater than 20 prescriptions per month. There were 2486 patient profiles reviewed and 60 prescribers targeted.

Intervention Goal:

The goal of this intervention was to decrease the number of prescriptions per utilizer issued by those prescribers targeted for a TAI visit and to facilitate the conversion of patients from a non-PDL to a PDL medication.

Intervention Results:

There were 488 patients screened and 60 prescribers targeted. Most of the physicians visited agreed to make an effort to review their patients' medications and change duplicative therapies and decrease over utilization when deemed clinically appropriate. An analysis of prescribing patterns of those prescribers targeted showed a 33.77% decrease in the number of prescriptions with a resulting 34.82% decrease in the dollars paid. The PUPM decreased by 25.69% compared to a decrease in the PUPM in the control group of 15.88%.

Cost Savings Analysis:

The PUPM in the control group for all non-PDL agents decreased $159.84. The PUPM in the target group decreased $310.89 for a net PUPM savings of $151.05.

RetroDUR Program –

The RetroDUR program was able to contact prescribers with educational materials related to the intervention and allowed individualized program education regarding the PDL.

REGULAR RETRODUR SUMMARY (letter interventions)

- Estimated Savings per utilizer per year for all interventions months was $7.56
- Annual Estimated Cost Savings for the RetroDUR Program for FFY 2003 was $808.92.

JANUARY 2003 — Over-utilization of albuterol inhalers without concurrent use of long-term controller medications

Purpose of Initiative:

The purpose of this initiative was to ensure that recipients receive optimal drug therapy at the lowest cost. NIH guidelines suggest for long-term control of asthma, patients with mild to severe persistent cases may benefit from concurrent use of long-term controller medications: inhaled corticosteroids, long-acting inhaled B_2 agonist, mast cell stabilizer, leukotriene modifier, or alternately (but not preferred) theophylline.

Methodology:

Of the 872 patient profiles screened, 764 were targeted for this intervention. A RetroDUR pharmacist notified 495 prescribe rs of the suspected under use of long-term controller medications.

Intervention Goal:

The goal was to encourage prescribers to utilize NIH guidelines for the long-term control of asthma.

Intervention Results:

Prescribers returned 159 letters indicating a change in therapy. The response rate for this intervention was 20.82%. Albuterol inhaler use decreased by 24.85%. The use of controller medications increased by 11.32% in the targeted group. The albuterol usage in the control group decreased by 22.25% compared to 16.77% decrease in the control group.

Cost Savings Analysis:

The PUPM in the control group for all non-PDL agents decreased $2.45. The PUPM in the target group decreased $3.08 for a net PUPM savings of $0.63.

ATTACHMENT 3.5 --continued-- RetroDUR Activity Details

APRIL 2003 — Proton Pump Inhibitor Long-Term Use

Purpose of Initiative:
The purpose of this intervention was to identify patients receiving Proton Pump Inhibitor (PPI) therapy for more than 4 months.

Methodology:
There were 29,198 claims reviewed for this intervention with 25,495 patients identified. A total of 861 patients were identified who met the criteria. Prescribers were notified and encouraged to consider a change to H-2 antagonist therapy.

Intervention Goal:
The goal of this intervention was to decrease the use of PPIs.

Intervention Results:
None, this intervention was not approved by the DUR Board due to lack of quorum and pressing other Board business.

Cost Savings Analysis:
None

SEPTEMBER 2003 — Lipotropic Dose Optimization

Purpose of Initiative:
The purpose of this intervention was to convert recipients on twice daily dosing of an HMG-CoA reductase inhibitor to a once daily dosing.

Methodology:
The claims of 19,741 patients who received a lipotropic medication in October 2003 were. The highest strength of each drug was filtered out due to the inability to change to a once daily dosing. Of those remaining, 247 patient letters were mailed out to 226 prescribers.

Intervention Goal:
The goal of this intervention was to convert patients on twice daily dosing of HMG-CoA Reductase inhibitors to once daily dosing.

Intervention Results:
None. This intervention implementation was delayed until December 2003.

Cost Savings Analysis:
None. This intervention implementation was delayed until December 2003.

Attachment 4:
Summary of DUR Board Activities

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 4
DUR BOARD ACTIVITIES SUMMARY DURING FFY2003

A. Indicate the number of DUR Board meetings held.

A. DUR Board meetings are held monthly. Twelve meetings were held during FFY 2003.

B. List additions/deletions to DUR Board approved criteria.

1. For prospective DUR, list problem type/drug combinations added or deleted.

The DUR Board approved two major changes to increase the effectiveness of the Pro-DUR criteria.

(1) PDL Program -- The DUR Board's efforts were highly concentrated on in-depth reviews and recommendations for a comprehensive PDL implementation (See Table 1.D for PDL Program Criteria Implemented from Aug 2002 to Aug 2003). Practitioners were encouraged to prescribe the preferred drug in a therapeutic class. If practitioners did not want to prescribe the preferred drug, they could go through the process to obtain prior authorization (PA) for Nonpreferred drugs.

Deleted: non-preferred

(2) Some Pro-DUR Edits Changed to PA -- The DUR Board adopted changing some ProDUR criteria from override able (soft) ProDUR edits to non-override able (hard) ProDUR edits requiring prescriber intervention to obtain PA.

(See Attachment 4.1 for DUR Board-approved ProDUR criteria modifications).

2. For retrospective DUR, list therapeutic categories added or deleted.

See Attachment 4.2 for additions of DUR Board-approved RetroDUR criteria.

C. Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens.

In FFY2003, OMPP consolidated the contractors responsible for each function of claims processing, ProDUR and RetroDUR analyses and interventions. OMPP was seeking coordination of prospective and retrospective DUR screenings. A single contractor allows for quick adjustment to each program with improvements as needed. Prior reports presented to the DUR Board on numbers of overridden ProDUR edits led to the development of the stricter ProDUR hard edits requiring PA.

Analyses of both ProDUR and RetroDUR edits and criteria have always been used by the OMPP and the DUR Board to help establish new cost-containment initiatives. It has been standard practice by the OMPP and DUR Board to expect that the contractor would develop and present innovative ideas on cost containment and therapeutic

ATTACHMENT 4 – continued--

appropriateness through DUR program efforts. ACS State Healthcare will uphold that standard and provide more RetroDUR and educational interventions over the next year.

D. Describe any policies used to encourage the use of therapeutically equivalent generic drugs. Include relevant documentation, if available, as ATTACHMENT 5.

The State of Indiana has a mandatory generic substitution statute. Indiana regulation was also added to require Prior Authorization for prescriptions written as "Brand Medically Necessary" when generic substitution is possible.

See attachment 5 for specific descriptions & relevant documentation.

E. Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring).

The DUR Board sets the types and quantities of DUR interventions.

FFY 2003 plans included a prior authorization program due to excessive overrides of certain ProDUR alerts: early refill, high dose, therapeutic duplication and drug-drug.

A comprehensive PDL Program was implemented, the goals of which were to improve quality of care while conserving Program expenditures. Provider bulletins and DUR Board Newsletters were reviewed and approved notifying prescribers and pharmacists about the programs.

IBM and TAI educational interventions about the PDL Program implementation were also reviewed and approved by the DUR Board. Finally, the DUR Board reviewed several studies by the MedStat group.

Attachment 4.3 contains meeting minutes highlighting involvement in DUR education.
Attachment 4.4 contain Provider Bulletins
Attachment 4.5 contain DUR Board Newsletters
Attachment 4.6 contains schedule and the PDL list
Attachment 4.7 contains several studies by the contractor, MedStat.

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

Attachment 4.1

PROSPECTIVE DUR CRITERIA CHANGES

CHANGES WERE FROM OVERRIDES TO PRIOR AUTHORIZATION (PA) REQUIRED

*Implementation Dates of Pro-DUR Criteria now Requiring PA

The DUR Board Adopted ProDUR Criteria Changes Listed Below by Problem Type

INAPPROPRIATE DOSE (HIGH DOSE)	THERAPEUTIC DUPLICATION	DRUG ALLERGY INTERACTION
1. **All Drugs except** Hydrocod/APAP, Oxycod/APAP; Oxycodone ***** (3/28/03)	1. **Thera.Dup**. See Table 1.B for Drug List * (7/22/03)	1.
2.	2.	2.
3.	3.	3.

INAPPROPRIATE DURATION	DRUG/ DRUG INTERACTIONS	DRUG DISEASE CONTRAINDICATION
1. **Early Refill *** (7/1/02)	1. **DD Severity Level 1 *** (1/15/03)	1.
2. **34-Day Supply for Non-Maintenance *** (7/1/02)	2.	2.
3.	3.	3.

OTHER *(specify)*	OTHER *(specify)*	OTHER **GENERIC APPROPRIATENESS** *(specify)*
1.	1.	1. **Brand Medically Necessary Indication *** (8/2001)
2.	2.	2.
3.	3.	3.

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

Attachment 4.2

RETRO-DUR CRITERIA
ADDITIONS

INAPPROPRIATE DOSE (HIGH DOSE)

1. NONE
2.
3.
4.
5.
6.
7.
8.

THERAPEUTIC DUPLICATION

1. NONE
2.
3.
4.
5.
6.
7.
8.

DRUG / ALLERGY INTERACTION

1. NONE
2.
3.
4.
5.
6.
7.
8.

INAPPROPRIATE DURATION

1. Albuterol / Over utilization*
2.
3.
4.
5.

DRUG / DRUG INTERACTION

1. NONE
2.
3.
4.
5.

DRUG / DISEASE CONTRAINDICATION

1. NONE
2.
3.
4.
5.
6.

OTHER: COST APPROPRIATENESS
SPECIFY

1. NONE
2.
3.
4.
5.
6.

OTHER: THERAPEUTIC APPROPRIATENESS
SPECIFY

1. **Iipid Lowering Agents / Dose Optimization**
2. **Sel.SerReupt.Inh.(SSRIs)/ Dose Optimization**
3. **Preferred Drug List Education**
4.
5.
6.

OTHER: GENERIC APPROPRIATENESS
SPECIFY

1. NONE
2.
3.
4.
5.
6.

FOR EACH PROBLEM TYPE, LIST (DRUGS / DRUG CATEGORY / DISEASE COMBINATIONS) FOR WHICH DUR BOARD CONDUCTED IN-DEPTH REVIEWS. PLEASE INDICATE WITH AN ASTERICK THOSE FOR WHICH CRITERIA WERE ADOPTED.

ATTACHMENT 4.3
INDIANA DUR BOARD MEETING MINUTE HIGHLIGHTS
October 2002 – September 2003

OCTOBER 2002

Marc Shirley, OMPP Pharmacy Director, stated that the projected completion date for the entire Preferred Drug Program (PDL) should be April 2003. After that time, the Therapeutics Committee would review the PDL twice per year. He stated that the PDL website will be enhanced to make it more informative and that the site can be accessed at either www.indianamedicaid.com or www.indianapbm.com.

The therapeutic classes reviewed included the Triptans, Thiazolidinediones (TZDs), ACEI/CCB combinations, ACEIs with Diuretics, ARBs with Diuretics and the BPH drugs. Actions taken were as follows:

- Triptans-The Board approved the Triptans and dispensing limits as recommended by the Therapeutics Committee.
- Thiazolidinediones (TZDs)-The Board approved the Thiazolidinediones and dispensing limits as recommended by the Therapeutics Committee.
- ACEI/CCB combinations-The Board approved the ACEI/CCB combinations as recommended by the Therapeutics Committee.
- ACEIs with Diuretics -The Board approved the ACEI/HCTZ combinations as recommended by the Therapeutics Committee.
- ARBs with Diuretics -The Board sent this class back to the Therapeutics Committee for more review in light of the new information on safety, efficacy and new indications.
- BPH drugs-The Board approved the BPH class as recommended by the Therapeutics Committee.

Scott Dunham, ACS, presented a proposal for ProDUR interventions to be performed by ACS for the next four quarters. Interventions suggested included:

- Excessive use of short-acting beta agonist
- Trental use in patients at risk for seizure disorders
- Oxycontin use exceeding every 12 hour dosing schedule
- First generation antihistamine use in patients over 65 years of age

Dr. Lindstrom, DUR Board Vice Chairman, advised ACS to submit intervention materials and scripts to the Board for its approval. It was agreed that all interventions would cease until further review by the Board. Mr. Shirley suggested that ACS do another presentation for possible initiatives they could perform for the RetroDUR, IBM and TAI programs.

Mike Sharpe, Health Care Excel (HCE), presented data on the current activity of the IRDP for the month of September 2002. The call center received 12,290 calls. Of the 9,039 prior authorization requests received, 8,044 were approved, 427 denied and 349 suspended. He made note that the proton pump inhibitors had transitioned to the PDL.

ATTACHMENT 4.3 --continued--

NOVEMBER 2002

Marc Shirley, OMPP Pharmacy Director, distributed copies of a report provided to the Board from the Indiana Board of Pharmacy. The report was based on data addressing utilization of stimulant medications in patients under the age of 18. Additionally, a report prepared by EDS concerning stimulant drug utilization by Medicaid patients was included. He reminded the Board that a report was due to the Joint Committee on Medicaid Oversight, the Indiana Legislative Council and the Medical Licensing Board. That report would analyze the information contained in both the EDS and Board of Pharmacy reports. Data management staff was working to compile all necessary components of the report, and OMPP was coordinating with the Board of Pharmacy to ensure the report was complete. They intended to have a draft to the Board prior to the December 2002 meeting and in a form the Board could approve and have distributed. Mr. Shirley stated that he had discussed the report requirements with legal staff and a determination was made that the report must analyze the information reviewed under subsection G. This information would include the two reports previously mentioned, plus any commentaries received from insurers. The Controlled Substance Advisory Committee must then issue a statement regarding whether this information indicates that stimulant medications are being disproportionately prescribed to children covered under Medicaid.

The Board added the class of ARBs to the PDL with the following criteria. All strengths of Micardis and Cozaar would be added with a limit of one tablet per day with the additional criteria of a step edit requiring failure with an ACEI within the previous year.

The therapeutic classes reviewed for Phase 6 of the PDL were the Macrolides, Fluoroquinolones, Cephalosporins, and Systemic Antifungals. Actions taken were as follows:

- Macrolides-The Board approved the Macrolides and dispensing limits as recommended by the Therapeutics Committee.
- Fluoroquinolones-The Board approved the Fluoroquinolones and dispensing limits as recommended by the Therapeutics Committee.
- Cephalosporins-The Board approved the Cephalosporins as recommended by the Therapeutics Committee.
- Systemic Antifungals -The Board approved the Systemic Antifungals and dispensing limits as recommended by the Therapeutics Committee.

Chris Johnson, EDS, referred to the Stimulant Drug Utilization Report prepared by EDS. The results had shown 61% of the targeted patients had a diagnosis of ADD and/or ADHD. Dr. Irick noted that modafinil should have been included in the list of drugs studied, due to the rise in illicit utilization of the product.

Scott Dunham, ACS, clarified the difference between TCP (Therapeutic Consultation Program), IBM (Intensified Benefits Management Program) and TAI (Therapeutic Academic Intervention Program). He explained that the TCP program is when a prescriber calls for a prior authorization. The IBM Program is when the prescribers are called by an IBM Pharmacist to educate them on the PDL process as it applies to specific patients. The TAI

ATTACHMENT 4.3 --continued--

Program has pharmacists in the field for the purpose of discussing PDL issues and educating providers on the TCP process. He then presented the proposed IBM, TAI and RetroDUR initiatives for the month. He emphasized that at this time the IBM interventions are only telephonic in nature, with the intent to discuss the PDL as the major goal. The suggested RetroDUR focus was the under-utilization of long-term controller medications in asthma patients. The Board approved telephonic educational IBM interventions to support the PDL, and the TAI and RetroDUR initiatives as proposed by ACS. Dr. Treadwell reiterated that all clinical or non-educational interventions must be approved by the Board prior to implementation.

Mike Sharp, HCE, presented data on the current activity of the IRDP for the month of October 2002. The call center received 12,079 calls. He made note that of the 9,231 prior authorization requests received, 8,407 were approved, 296 denied, and 372 suspended. Kate Whitaker, Medstat, presented a preliminary analysis report on NSAIDS & Cox-2 inhibitors. She discussed the methodology utilized and the analysis of the results. The study looked at the impact of the IRDP on utilization, cost and patient outcomes. The study included 6 months of data from January 2002 through June 2002 (after the implementation of the IRDP) versus 6 months of data from January 2001 through June 2001 (before IRDP).

Representatives from Harmony Health Plan presented a packet of documents containing a copy of the letter that would be sent to prescribers discussing the formulary. The proposed formulary was approved.

Election of officers: Dr. Terry Lindstrom-Chairman for the year 2003. Dr. John Wernert-Vice Chairman for the year 2003.

DECEMBER 2002

Melanie Bella, OMPP Director, presented Board members with copies of the 2004 and 2005 budget forecast and discussed highlights for the next biennium.

The therapeutic classes reviewed for Phase 7 of the PDL included the Bone Resorption Agents/SERMS, Heparin and Related Preparations, and the Antiemetic/Antivertigo Agents. Actions taken were as follows:

- Bone Resorption Agents/SERMS-The Board approved the Bone Resorption Agents/SERMS and dispensing limits as recommended by the Therapeutics Committee.
- Heparin and Related Preparations-The Board approved the Heparin and Related Preparations and dispensing limits as recommended by the Therapeutics Committee.
- Antiemetic/Antivertigo Agents-The Board approved the Antiemetic/Antivertigo Agents as recommended by the Therapeutics Committee.

Mike Sharp, HCE, presented an update on the implementation of the hard edits for the high dose (HD) alerts. He discussed the types of hard alerts and what actions dispensing pharmacists perform at POS in response to these alerts. Additionally, he presented an IRDP prior authorization update.

ATTACHMENT 4.3 --continued--

Richard Van Dyke, OMPP, presented the SEA 228 report regarding stimulant drug use in recipients under the age of 18. The Board asked numerous questions regarding the report.

Dr. Irick expressed concern over providers giving these drugs outside the scope of their specialty. Dr. Wernert summarized the Board's conclusions in a document to be attached to the report. The Board approved the report for distribution.

JANUARY 2003

Dr. Lindstrom stated that the purpose of the DUR Board was to ensure appropriate use of medications consistent with OMPP policy. He described the challenges the Board would be facing in the coming year. These included:

- To continue in the further development of the PDL, clarifying the procedure for semi-annual PDL review and that new drugs must be evaluated within six months of FDA approval.
- To review the risk-based managed care (MCO) formulary.
- To ensure that all required reports from the Board are completed and submitted to the Joint Commission of Medicaid Oversight Committee.
- To provide more outcomes analysis for the PDL and IRDP by working with ACS to perform outcomes and PDL analysis.
- To define "therapeutic class" for the purposes of the Board as well as to define which drugs are within a particular therapeutic class.

Melanie Bella, OMPP Director, announced a modification in the current budget. The state's FFP share may be updated to a higher rate. This would have a positive impact to the Medicaid budget. She stated that OMPP still needed to address the overall budget shortfall and that they are currently reviewing additional cost savings initiatives.

There were no recommendations from the Therapeutics Committee for the following drug classes:

- Leukocyte Stimulants and Hematinics -The Therapeutics Committee had many questions in regard to this class of medications. The Board stated that the Therapeutics Committee is charged with making clinical recommendations to the Board and not to get bogged down with procedural questions. Additional questions or concerns should be included in their recommendations to the Board.
- Smoking Cessation Products -The Therapeutics Committee wanted clarification on what the current law stated for this class of drugs.

David George, ACS, requested approval for an asthma specific RetroDUR letter to be mailed to physicians. The total number of providers receiving this RetroDUR letter would be 606 out of an approximate total of 11,112. The Board approved the initiative and letter.

Mike Sharp, HCE, informed the Board of a meeting with Larry Sage from the Indiana Pharmacists Alliance (IPA). IPA was willing to create a subgroup to work with ACS/HCE on new initiatives as well as to disseminate information to member pharmacists. He then

ATTACHMENT 4.3 --continued--

presented the IRDP update for last month and provided a report on the drug-drug alerts that were recently implemented. HCE had been receiving a number of calls that suggested that the alert was improving patient care. The Board wanted a status on the therapeutic duplication alerts and expressed concern about providing educational information to provider pharmacies. Mr. Sharp explained that each edit has been documented in a provider bulletin and that Mr. Sage would be helpful in creating educational opportunities for pharmacy providers. The therapeutic duplication alerts were currently handled with a soft edit but a hard alert process was being developed. ACS/HCE will present a list of therapeutic duplication classes to the Board, along with the appeal process prior to initiating any hard edits.

The Board voted to send Forteo® back to the Therapeutics Committee for review.
The Board voted to add Strattera® to the PDL.

David George stated that ACS would be delivering quarterly recommendations to the Board for changes or additions to the OTC formulary in the coming months.

FEBRUARY 2003

Dr. Lindstrom, DUR Board chairman, offered highlights from meetings he had attended since the last Board meeting. At a meeting with OMPP, he discussed an outcomes analysis and the impact of the PDL. He received a draft letter pertaining to the outcomes analysis report for the Medicaid Oversight Committee. The second meeting involved a visit to the ACS facilities in Atlanta, Georgia. During this meeting, he discussed performing educational versus interventional activities. He also discussed the definition of "intervention" as per Indiana statute, the therapeutic classifications based on GC3 codes, and how to apply these definitions. The third meeting was with a working group of the Board and Therapeutics Committee. This meeting was initiated to develop a common understanding of various statute definitions and to develop the framework for utilizing GC3 codes in defining therapeutic classes reviewed for the PDL. The importance of communicating Board and Therapeutics Committee schedule changes to community providers via the provider bulletins was stressed during the meeting.

The therapeutic classes reviewed for Phase 8 of the PDL were specified as being Skeletal Muscle Agents, Urinary Tract Antispasmodics/Anti-Incontinence Agents, Biguanides/Other Hypoglycemic Agents, Brand Name Narcotic Agents, Fibric Acid Agents, Bile Acid Sequestrant Agents, Forteo® and Smoking Cessation Products. Actions taken were as follows:

- Skeletal Muscle Agents -All generic agents in this class were added to the PDL with the exception of carisoprodol. Due to the significant abuse potential of carisoprodol, all dosage forms would require prior authorization.
- Urinary Tract Antispasmodics/Anti-Incontinence Agents -All immediate release generics were added to the PDL, with step edits for Detrol LA® and Ditropan XL® (current patients on these agents were to be grandfathered).
- Biguanides/Other Hypoglycemic Agents -All generic 2nd generation sulfonylurea agents, generic metformin, Glucotrol XL®, Amaryl®, Glyset®, Precose®, Prandin®, and Starlix® were added to the PDL. Additional step edits for Avandamet®,

ATTACHMENT 4.3 --continued--

Glucovance® and Metaglip® were implemented (current patients on these agents to be grandfathered).

- Brand Name Narcotic Agents-All generic agents were added to the PDL. All combination acetaminophen/narcotic products were limited to a total of 3 grams of acetaminophen per day. Additionally, all IRDP limits on agents previously subject to IRDP criteria were maintained. The limit on OxyContin® 80mg was decreased to 60 tablets in 25 days, and PA's for all controlled substances were limited to six months. Ultracet was sent back to the Therapeutics Committee for clarification of the recommendation.
- Fibric Acid Agents-All generic formulations of gemfibrozil, Tricor® 160mg and 200mg and LoFibra® 200mg were added to the PDL (patients presently on other doses of Tricor® to be grandfathered).
- Bile Acid Sequestrant Agents-Due to significantly higher cost of colestipol and cholestyramine tablets and unit dose packets, only the bulk powder cans were added to the PDL.
- Forteo-The Board sent this product back to the Therapeutics Committee to develop criteria for a PA process.
- Smoking Cessation Products-The Board sent this class back to the Therapeutics Committee to get a specific list of agents and recommendations.

The Board received feedback from a meeting between ACS and the Indiana Pharmacists Association concerning ProDUR edits. The discussion included the initial impact of the Drug/Drug (DD) Severity Level 1 edit. Additional discussion centered on the upcoming High Dose (HD) edit rollout and the criteria to be developed for the Therapeutic Duplication (TD) edit. Based on recommendations from the group, the Board voted to exclude warfarin from the early-refill (ER) edit, since the strength of this medication is frequently adjusted. The group also recommended the removal of the IRDP edit on the H2 Antagonists so to encourage the use of H2 Antagonists instead of PPIs. The Board forwarded this recommendation to the Therapeutics Committee for consideration.

David George, ACS, submitted a proposal for a RetroDUR intervention. The proposed intervention would look at PPIs being used for greater than 4 months, and assess the step-down therapy of PPIs. Dr. Lindstrom asked that the time period cover September 2002 until March 2003.

The Board added OTC Alavert® 10mg, Claritin® 10mg, Claritin® 10mg Redi-Tabs, Claritin® 10mg/10ml Syrup, and Claritin®-D 24 hour to the OTC Drug Formulary.

Mike Sharp, HCE, presented data for the IRDP/ProDUR edit activity for the month of January 2003. Comparing January 2003 to January 2002, he commented that the spike in activity was due to reauthorization of programs started a year ago. The number of overrides granted went down significantly due to IRDP interventions.

ATTACHMENT 4.3 --continued--

Mr. Buck spoke about the Medstat IRDP study of brand name NSAID/Cox-2 Inhibitors. He stated his opinion that the reduction of cost did not take into account increased medical costs, which may have occurred due to the shift of patients from Cox-2 Inhibitors/brand name NSAIDS to generic NSAIDS. Costs such as increases in emergency room/office visits, hospital admissions and utilization of PPIs by patients switched to generic NSAIDS were not considered. He suggested analyzing medical costs for Cox-2 Inhibitors/brand name NSAID utilizers and compare these with generic NSAID utilizers to insure that cost shifting and poor patient outcomes did not occur as a result of the IRDP. Additionally, he commented that the study did not compare the PA group to the non-PA group with regard to patient outcomes and felt that the 2% inflation assumption may not be accurate. The Board referred this analysis to Dr. Mychaskiw (health economist Board member) for evaluation and asked Medstat to address these concerns.

MARCH 2003

The Board approved the use of the GC3 classification system as the foundation for developing the therapeutic classes for the PDL.

Marc Shirley, OMPP Pharmacy Director, updated the Board on the implementation of ACS's PDCS X2 claims processing system, which went live the previous week. He stated that ACS has been very responsive to providers with fixing system issues. Some OTC products formerly considered supplies under the old EDS system, were classified as drugs (e.g. Pedialyte) under the new system. This was causing rejected claims, since electrolyte maintenance medications were not on the OTC Formulary. The Board voted to add the OTC electrolyte maintenance medication to the OTC Drug Formulary.

Melanie Bella, OMPP Director, discussed the proposed Medicaid budget. This bill would fund Medicaid at the same amount, which would require Medicaid to find an additional cost savings of approximately $263 million. The prescription drug spend was the second largest and fastest growing Medicaid budget item. She stated that the financial crisis within the high-risk (ICHIA) program would require ICHIA to find economical alternatives. One possible alternative would mandate that the DUR Board advise ICHIA on disease management and PDL development.

The therapeutic classes reviewed for Phase 9 of the PDL were specified as being the Ophthalmic Mast Cell Stabilizers/Eye Antihistamines, Miotics/Other Intraocular Pressure Reducers, Ophthalmic Antibiotics, Otic Antibiotics, Vitamin A Derivatives, Anitpsoriatics, Leukocyte (WBC) Stimulants, Hematinics, Ultracet®, Forteo® and Smoking Deterrent Agents. Actions taken were as follows:

- Ophthalmic Mast Cell Stabilizers/Eye Antihistamines -Alamast, Livostatin® and cromolyn® were added to the PDL. A step edit for Patanol®, Optivar and Zaditor® required failed treatment with a PDL agent within the last 12 months (current prescriptions would not grandfathered).

ATTACHMENT 4.3 –continued--

- Miotics/Other Intraocular Pressure Reducers -The Board approved this class as recommended by the Therapeutics Committee with the exception of Alphagan® P, which was sent back to the Committee for additional review of cost and clinical efficiency considerations.
- Ophthalmic Antibiotics -The Board approved this cla ss as recommended by the Therapeutics Committee.
- Otic Antibiotics -The Board approved this class as recommended by the Therapeutics Committee with the exception of Cipro® HC, which was sent back to the committee for additional review of clinical efficiency considerations.
- Vitamin A Derivatives-The Board approved this class as recommended by the Therapeutics Committee with an age limit of less than twenty-five and a step edit for Differin®, which required failed treatment of a tretinoin product within the pre vious 12 months.
- Anitpsoriatics-The Board approved this class as recommended by the Therapeutics Committee.
- Leukocyte (WBC) Stimulants -The Board approved this class as recommended by the Therapeutics Committee.
- Hematinics-The Board approved this class as recommended by the Therapeutics Committee.
- Ultracet®-The Board voted to exclude this agent from the PDL.
- Forteo®-The Board voted to exclude this agent from the PDL and accepted the Therapeutics Committee's recommendations for Prior Authorization criteria.
- Smoking Deterrent Agents -The Board approved this class as recommended by the Therapeutics Committee.

David George, ACS, presented the updated ICD-9 codes used for antibiotic prescription refills. Dr. Treadwell commented on the need to retain the cellulitis related ICD-9 codes as well as add a code for "bacterial skin disease NOS". The Board adopted these codes with Dr. Treadwell additions.

Mike Sharp, HCE, presented the data for the IRDP/ProDUR edit activity for the month of February 2003. He explained that the trigger date for the early-refill (ER) edit was an on-hand supply of 25% as per claims history.

The MCO Formulary Review was tabled until next month when a side-by-side comparison of risk-based to fee-for-service drug lists would be available.

Dr. Mychaskiw provided the Board with his comments on the Cox-2 Inhibitor/brand name NSAID analysis report. He highlighted the potential limitations with using claims data, requirements of the study and the impact of the assumed inflation rate within the analysis.

ATTACHMENT 4.3 --continued--

APRIL 2003

Brian Musial reported that the Therapeutics Committee completed the review of all drug classes for the PDL during their last meeting. The first of two annual reviews of the entire PDL will occur in August 2003.

Millie Houtekier, Medstat, presented a RetroDUR analysis of IRDP impact on utilization and expenditures for the Proton Pump Inhibitor class. Their findings were summarized as follows:

- The IRDP realized a 4.4 million dollar savings in the past year for this class of drugs.
- There was a 24% decrease in the number of PPI prescriptions.
- The total number of prescriptions per recipient decreased by 30%.
- The total number of prescriptions per 1000 recipients decreased by 25%.
- The analysis stated that there was a cause and effect correlation between the number of prescriptions and the savings amount.
  - Net payments decreased by 23 %,
  - Payments per recipient decreased by 29%,
  - The average number of prescriptions per recipient pre-intervention was five and post-intervention was around three prescriptions.
- Those patients over 65 years of age had the highest utilization of PPIs both pre and post initiation of the program. But this same population had the highest decrease in number of prescriptions per recipient from 5.3 prescriptions/recipient to 3 prescriptions/recipient.
- The analysis showed that the largest utilizers were impacted the most by the program, with a savings of 1.2 million dollars for this population.
- The impact on patient quality of care outcomes was summarized as follows:
  - The change in the number of hospitalizations and emergency room/office visits was negligible for those recipients who were on PPIs prior to the IRDP and then granted a PA under the IRDP.
  - For the 7% of recipients (2,830 people) denied a PA under the IRDP, the number of hospitalizations and emergency room/office visits decreased.

The therapeutic classes reviewed for Phase 10 of the PDL were Antiviral (Influenza) Agents, Antiviral (Antiherpetic) Agents, Topical Antifungals, Vaginal Antimicrobials, Topical Estrogen Agents, and Antiulcer/H. pylori Agents. Review of Cipro HC® and Alphagan P® was tabled until the next meeting. Actions taken were as follows:

- Antiviral (Influenza) Agents -The Board adopted the Therapeutics Committee recommendation to add all the generic formulations of amantadine and rimantadine to the PDL.
- Antiviral (Antiherpetic) Agents -The Board adopted the Therapeutics Committee recommendation to add all the generic formulations of acyclovir, Valtrex®, and Zovirax® 200 capsules and 400mg tablets and suspension to the PDL.

ATTACHMENT 4.3 --continued--

- Topical Antifungals -The Board adopted the Therapeutics Committee recommendations for Topical Antifungals with the additional criteria of adding all generic formulations of econazole to PDL. The Board also moved griseofulvin tablets and Grifulvin®V to the PDL. Additionally, the Board moved Fulvicin®, Grisactin® and Gris -Peg® to non-PDL under oral antifungal agents.
- Vaginal Antimicrobials -The Board adopted the Therapeutics Committee recommendation to add all formulations of generic over-the-counter products, clotrimazole, miconazole and tioconazole to the PDL.
- Topical Estrogen Agents -The Board adopted the Therapeutics Committee recommendation that all agents in this class be included on the PDL.
- Antiulcer/H. pylori Agents -The Board adopted the Therapeutics Committee recommendation for this class of agents.

David George, ACS, reported that the ProDUR edits for Therapeutic Duplication (TD) would be phased-in, with the ACEI and ARB classes being the first two implemented. ACS continues to work closely with the Indiana Pharmacy Association regarding future ProDUR edit implementations.

Mike Sharp, HCE, presented the data for IRDP/ProDUR edit activity for March 2003. During this month, HCE processed 11,602 PA requests and took 4,043 phone calls for a total of 15,645 requests handled. He stated that within the next few months many drugs would be transferred from the IRDP to the PDL. HCE had been working with ACS to ensure a smooth transfer of all PA's granted by HCE. This would ensure that providers would not have to call to re-authorize these drugs until the previous PA had expired.

MAY 2003

Melanie Bella, OMPP Director, presented an update on the Medicaid budget.

- OMPP was working to find additional ways to save $218 million in order to close out positive in 2005.
- They have been working on the provider rebate reporting process.
- The managed care program was being expanded to include Porter and LaPorte counties for 2004. The criteria used in targeting counties were clarified for the Board. The criteria is that a county has to be in the top 20% of the population in Hoosier Healthwise, must be adjacent to a metropolitan area and have a minimum of two managed care organizations.
- There was a provision to institute a nursing home quality assessment. OMPP would have some influence on that process. The Budget Bill required that any changes made to the nursing home reimbursement must first have the approval of the Medicaid Oversight Committee.
- She indicated that OMPP was on target for their chronic disease management program, which will begin with diabetes and congestive heart failure. They will be partnering nurse care managers with physician teams and providing them with call centers and a centralized data registry. OMPP would be seeking DUR Board support and guidance in the future, looking for ways to utilized pharmacy data.

ATTACHMENT 4.3 --continued--

Kate Whitaker, Medstat, presented their RetroDUR study on the IRDP tramadol program.

- There was a $1.3 million savings following the implementation of this program.
- There was a 65% decrease in prescriptions written for tramadol following implementation of this program.
- The actual prescriptions per recipient went from 3.5 to 6.6 per recipient.
- Net payments decreased by 53%, but there was an increase of payments per recipient of about 150%.
- There was a significant decrease in prescriptions provided to children under the age of 18.
- The health care experiences in those recipients converted from tramadol to an alternative were higher after implementation of the program.
  - Office visits increased by 12%
  - Emergency room visits increased about 18-20%
  - Inpatient admissions increased about 30%

Marc Shirley, OMPP Pharmacy Director, informed the Board of a DUR Newsletter article that addressed the issues of prior authorization and Brand Medically Necessary. The article focused on the increased expenses incurred when a prescriber indicated BMN for a drug when a therapeutically equivalent generic was available. Ms. Perry suggested that consumer education regarding the cost of drugs and alternative therapy was needed.

Scott Dunham, ACS, presented the PDL issues tabled from last month.

- Alphagan P was excluded from the PDL, but current patients would be grandfathered for 12 months.
- Cipro HC was added to the PDL, but limited to children 12 and under.

The Board reviewed the MCO's formulary comparison report.

- The Board approved the restrictions and deletions to the formulary proposed by Harmony Health Plan.
- Managed Health Services (MHS) presented their formulary change requests, which included instituting a prior authorization requirement for atypical antipsychotics. The Board felt that this was an inappropriate use of the prior authorization process and that there were other methods to educate providers. They suggested that MHS develop alternative ways to address these issues. The Board moved to not approve the proposed MHS formulary, and asked that MHS resubmit their formulary document.
- The Board asked that a new document be created by OMPP, which indicated a side-by-side comparison of the PDL and MCO formularies. The Board requested that this document show which agents were covered, which were covered but has some type of restriction(s) and which agents were restricted.

ATTACHMENT 4.3 --continued--

JUNE 2003

The Board adopted the FFY 2002 DUR Annual Report minus the DUR cost savings analysis portion that would subsequently be provided by ACS. ACS would work with OMPP on a revised methodology approach in the ProDUR and RetroDUR cost savings sections of this report.

Scott Dunham, ACS, presented the following topics:

- Therapeutic Classification - Mr. Dunham reviewed the Indiana Code 12-15-35-17.5, which defined a therapeutic class as a group of pharmacological agents primarily characterized by a significant similarity of the biochemical or physiological mechanism by which these agents resulted in the intended clinical outcome. He stated that the GC3 codes developed by First DataBank provided a systematic and logical foundation to rearrange codes into therapeutic classes for the PDL. The first alpha character represented the organ system; the second numeric character was the pharmacological grouping, and the third alpha character provided classification by a physiological response. A handout was provided that gave details of what the PDL would look like under this classification system. Mr. Dunham felt that this would provide an easier way for the provider community and the public to understand the PDL. The Board tabled putting the PDL out by GC3 Code classification until the Board received comparable information regarding what other states had done with grouping therapeutic classes.
- Indiana OTC Drug Formulary - The Board approved the Indiana OTC Drug Formulary additions proposed by ACS State Healthcare, which gave health care professionals the option of prescribing less expensive OTC drugs in the place of the more expensive legend drugs.
- Therapeutic Duplication (TD) ProDUR Hard Edit Rollout - ACE inhibitors and ARBs will be set to post hard alerts for therapeutic duplication effective July 21, 2003. These edits will require prior authorization from Health Care Excel. The proposed rollout after that would be calcium channel blocking agents, lipotropics, diuretics and then the antiinfectives.
- IBM/TAI Proposed Initiatives - Mr. Dunham proposed an initiative of the dose optimization of SSRIs. The purpose of the IBM/TAI initiative would be to identify patients receiving multiple daily doses of SSRIs and then request that prescribers consider switching to equivalent single daily dose. This change from multiple daily dosing to once daily dosing would eliminate program waste and produce a cost savings for the Medicaid program. The Board approved the initiative.

Dr. Michael Sha, presented the Therapeutics Committee's recommendations to the Board. The therapeutic classes reviewed were the Proton Pump Inhibitors (PPIs) and the Thiazolidinediones (TZDs).

- PPIs - The Board approved the removal of the current H2 edit, limited the dispensing quantity of H2s to 60 tablets in 30 days. Additionally, the Board implemented a step edit for PPIs that required a failed trial of an H2 in the previous six months and limited the quantity of the PPI dispensed to 30 units in 30 days.

ATTACHMENT 4.3 --continued--

- TZDs - The Board approved a step edit for TZDs that required the use of metformin in the previous six weeks and limited the quantity dispensed to 30 tablets per 30 days. Patients currently taking a TZD would be grandfathered. The Board approved Avandia 4 and 8mg, and Actos 15, 30, and 45 mg as the PDL products.
- The Board approved Dr. Sha's suggestion to put the OTC Drug Formulary under the review of the Therapeutics Committee.

Brian Musial emphasized that due to time constraints, concerned individuals, physicians and pharmaceutical companies should provide their information to the Therapeutics Committee prior to meetings.

Dr. Donald Trainer, MHS Medical Director, provided the Board with the following documents:

- A listing of the MHS Pharmacy and Therapeutics Committee members and their specialty areas of practice.
- A copy of the MHS current PDL.
- The proposed changes to the MHS 2003 Drug Formulary. He noted that the clinical edits for current MHS formulary medications would grandfather anyone currently on those medications. He offered these additional clarifications:
  - Zithromax 1gm was excluded and it would be covered.
  - Diflucan 100 and 200mg were covered with 14-day limit. Diflucan 150mg limited to one tablet per prescription
  - The specialty-physician types of prior authorizations were already in existence and would be treated differently.
  - Patients currently on medications proposed for deletion would be grandfathered

The Board approved the changes to the MHS formulary and suggested calling it a PDL.

Dr. Grissell, HCE, presented the IRDP/ProDUR data for the months of April and May 2003. The total number of requested processed was 12,401. He did not have complete totals for the different categories, but HCE could provide them if the Board requested.

JULY 2003

Melanie Bella, OMPP Director, presented an update on the Medicaid budget. She stated that the 2002-2003 budget closed June 30, 2003. Medicaid achieved its goal of living within the appropriation for 2002-2003. She thanked the Board for their role in that success. Looking forward into 2004-2005, she stated that Medicaid still faced some pressure. They had a deficit in April reported at $217 million. Since that time, the Federal Government did allocate federal fiscal relief and Indiana's estimated share was about $168 million in the form of an enhanced federal match. This left a $50 to $54 million deficit going forward into 2004-2005. The office was thankful for the federal investment into the program, but it did not alleviate the pressure to make the changes needed to have a sustainable and financially viable program.

ATTACHMENT 4.3 --continued--

- To better manage the program and resources, the office started the disease management program in the central region in July 2003. The northern region would be added January 2004 and the southern region in April 2004. During that time, the disease states of hypertension and HIV/AIDS would be phased-in. The framework for this program was developed with the Department of Health. Its goals were:
  - to infuse resources into the existing public health infrastructure,
  - to better educate patients to deal with their condition,
  - to use the public health system as a link between the case management and ongoing primary care.
- The office chose not to outsource this program to a commercial vendor, but instead assembled a network of strong partners, including:
  - The Indiana Minority Health Coalition
  - The Primary Healthcare Association
  - Life Mark-operated their call center
  - McCall Institute would be helping them develop evidence-based guidelines. They would be using the Stanford self-management patient education model to give patients the tools to help them manage their disease.
- The most chronically ill patients would be assigned to a care manager provided by the Minority Health Coalition and the Primary Healthcare Association. The remainder of the patients would be managed by the call center.
- These were some of the positive items that the Office was performing to control utilization, improve health care quality and take some of the burden off of the providers who continued to participate in the program. The successful management of these conditions was largely dependent on the ability to comply with the medication regimens.

Marc Shirley, OMPP Pharmacy Director, presented a cost containment initiative, developed by ACS and OMPP in accordance with State Statue IC 12-15-35-5-7, to the Board. This statue allowed limitations on drug refills, and allowed OMPP to place limits on quantities dispensed or frequency of refills for the purpose of preventing fraud, abuse, waste, over-utilization or inappropriate utilization. The initiative was based on the requirement that 90-day supplies would be dispensed for selected maintenance medications so to conserve dispensing fee expenditures. Long-term care would be excluded from this requirement. He added that this information has been shared with the Indiana Pharmacist Association. The Board approved this initiative and asked ACS to expand the analysis over more than one month. Mr. Shirley also presented a document from OMPP and ACS, which contained a synopsis of the history of therapeutic classification using GC3 codes.

Dr. Karen Amstutz, MDWise Medical Director, described her organization as a provider-owned managed care organization located in Marion and Lake counties. A handout from MDwise contained proposed changes to their PDL, developed by the provider networks in conjunction with MDwise staff. She explained the process and discussed a few of the changes recommended. The Board accepted the MDwise formulary with the following changes:

- Diflucan 100mg and 200mg tablets and Diflucan suspension would be available without a quantity limit for diagnosis HIV and immunocompromised.

ATTACHMENT 4.3 --continued--

- Diflucan suspension step edit would include other prior treatment for tinia capitis with griseofulvin.
- Tretinoin and Benzamycin to require PA for age greater than 21.
- Vancenase needed to be moved in with the Rhinocort and Rhinocort AQ.

John Barth, OMPP Managed Care Director, presented two reports offered by ACS and the three MCO's. Scott Dunham, ACS, reviewed the therapeutic categories portion of the reports. The document was a comparison report and the other was a packet of three separate reports. He gave a brief overview of the format set up by ACS on the comparison document. Larry Harrison, MHS, explained how the documents were developed, discussed how clinical edits were noted in the reports and presented their preferred drug list.

- Hoosier Healthwise has three MCO plans. MHS was the only plan that is a statewide network. MDWise functioned in the central and northern parts of the state and is focused in Marion and Lake counties. Both of these plans were based in Indianapolis. Harmony Health Plan was based in Gary and functioned in the northern part of the state.
- The Board questioned the three MCO's on their Patient Satisfaction Survey results and how they were addressing grievances, several of which pertained to pharmacy staff not being educated on the re-adjudication process as it relates to emergency supply dispensing. Mr. Harrison commented that Script Solutions was the prescription benefit manager, and that they had contacted the individual pharmacists/pharmacies and the chain drug stores. Megan Schaffer, Harmony Health, stated that they had mechanisms in place to improve customer satisfaction.
- The Board's function, as relates to these plans, would be through its recommendations made in the annual report to the Medicaid Oversight Committee. Beth McCarty, MDWise, explained the difficulty in putting together the initial template and having to incorporate different classifications of drugs. Dr. Lindstrom clarified that the three MCO's spreadsheets were for the calendar year 2002. The Board wanted three additional categories added as an addendum and presented as an updated report during the September 2003 meeting. Dr. Eskew suggested the Board send the updated and corrected data to the Oversight Committee as an attachment with a coversheet.

Kate Whitaker, Medstat, presented their ongoing evaluation of the Indiana Rational Drug Program.

- Her first item was a follow-up to the tramadol study reported at the May 2003 meeting. Ms. Whitaker presented the breakdown in the frequency of office visits/hospital admissions following prior authorization denials for tramadol. These figures were compared to patients who received the prior authorization for tramadol. The findings were:
  - Those individuals who received a denial for tramadol and then received an alternative medication, had a higher rate (~23%) of admissions than the general population.
  - There was not a significant difference in the reasons for visits/admissions between those receiving tramadol and those denied tramadol.

ATTACHMENT 4.3 --continued--

- Major findings of the Medstat study on Synagis® were:
  - There was a 59% decrease in prescriptions for Synagis® following its inclusion into the program.
  - There was a concurrent shift of about 23-24% of children 2 years of age or younger into Risk Based Managed Care (RBMC) which contributed to the decrease in prescriptions.
  - There was a decrease from 29 prescriptions per thousand children to 15 prescriptions per thousand children. This translated to a 54 % decrease in expenditures for this drug equivalent.
  - An outcomes analysis did not find any children who were admitted or who had office visits for RSV in either the group.

Scott Dunham, ACS, presented a proposed DUR Board Newsletter. The Board approved the newsletter. He also presented the proposed IBM/TAI intervention for the month of August entitled, "High Utilization by Number of Prescriptions Received per Beneficiary." The purpose of this initiative was to identify the patients who would benefit from a comprehensive clinical profile review with a specific focus on therapeutic duplication, over-utilization, generic utilization and preferred drug utilization. Dr. Smith stated that he found these words troublesome and suggested accessing the state Medicaid resources kit available on the internet regarding prescriptions and review, for a discussion on the pros and cons of prescription limitation. He offered the website and felt that it addressed everything being said, that limits are completely arbitrary, reflecting no patient sensitivity, that they operate on pure financial motivation and express no concern about outcomes. The Board did not proceed forward with ACS's proposal at that time. They wanted to see a script and flow chart on how this intervention would be handled.

Dr. Ted Grissell, Health Care Excel, presented IRDP/ProDUR data for the month of June 2003. The report showed a total of 8,081 approved prior authorizations, 472 denials and 364 suspensions.

AUGUST 2003

The Therapeutics Committee presented their recommendations from the first semi-annual review of the PDL. There were 11 therapeutic groups reviewed and the recommendations were as follows:

- ALLERGY AND ASTHMA AGENTS-The Board accepted the Therapeutics Committee recommendations for PDL changes in the class of allergy and asthma agents as follows:
  - *Beta Agonists*-Remove albuterol tablets, both brand and generic, from the PDL.
  - *Non-Sedating Antihistamines*-Add all strengths and formulations of OTC loratadine to the PDL. Implement a step edit for Allegra® (patients must have failed a two-week trial of OTC loratadine within the previous three months). Zyrtec® syrup to remain on the PDL for children six years of age and under.
  - *Leukotreine Modulators*-Implement a step edit for Singulair® to encourage the use of this medication in asthmatic patients only. Patients must have had a methylxanthine, a beta agonist, and/or an oral corticosteroid within the past six months on their claims history.

ATTACHMENT 4.3 --continued--

- *Nasal corticosteroids*-No changes recommended.
- *Combined beta agonist/corticosteroids*-Advair® to remain on the PDL, but implement a step edit for the Advair® 500/50 strength. Patients must have failed Advair® 100/50, Advair® 250/50 or any strength of Flovent® within the past 30 days.

- ANTI-INFECTIVE AGENTS-The Board accepted the Therapeutics Committee's recommendations for PDL changes in the class of antiinfective agents as follows:
  - *Antiherpetic agents*-Remove Zovirax® brand suspension from the PDL. Valtrex® to be PDL if the patient's medication history in the past 6 months included antiretrovirals.
  - Antiviral Influenza agents-No changes recommended.
  - Cephalosporins-No changes recommended.
  - *Fluoroquinolones*-Add Cipro® XR to the PDL with a quantity limit of 3 tablets per prescription, no refills allowed. Add Factive ® to the PDL with a 14-day limit.
  - *Macrolides*-No changes recommended.
  - *Ophthalmic Antibiotics*-Add Ciloxan® 0.3% drops to the PDL. Make Vigamox, Zymar and Ciloxan Ophthalmic Ointment non-PDL.
  - *Ophthalmic Antibiotic/Corticosteroid combinations*-No changes recommended.
  - *Otic Antibiotics*-No changes recommended.
  - *Systemic Antifungals*-Diflucan® to be clarified on the PDL to state that only the 150mg strength has the 2 tablet limit. The 100mg and 200mg and suspension have no limits.
  - *Topical Antifungals*-No changes recommended.
  - *Vaginal Antimicrobials*-No changes recommended.
- CARDIOVASCULAR AGENTS-The Board approved the Therapeutics Committee's recommendations for PDL changes in the class of cardiovascular agents as follows:
  - *ACE Inhibitors*-Add generic moexepril 7.5mg to the PDL as well as all strengths of generic Univasc® as they become available in the future.
  - *ACE Inhibitors/Calcium Channel Blockers*-Add Tarka® to the PDL.
  - *ACE Inhibitors/Diuretics*-No changes recommended.
  - *Alpha Adrenergic agents*-No changes recommended.
  - *ARB's*-Add Benicar® with step edit for failure of an ACE Inhibitor.
  - *ARB's/Diuretics*-Add Benicar®/HCT to the PDL.
  - *Beta Blockers*-Add InnoPran® XL to the PDL. Add Coreg® to the PDL with a step edit that requires that patients must have a current prescription for a diuretic and limit Coreg to 90 tablets per dosage strength per 30 days.
  - *Calcium Channel Blockers*-No changes recommended.
  - *Selected Aldosterone Receptor Antagonists*-Inspra ® remain PDL neutral until cost and utilization data becomes available.
  - *Loop Diuretics*-No changes recommended.
- CNS AGENTS- The Board approved the Therapeutics Committee's recommendations for PDL changes in the class of CNS agents as follows:
  - *Anti-emetics*-Add Emend® to the PDL with a quantity limit of 6 tablets per month.
  - *Brand Name Narcotics* -No changes recommended.
  - *NSAIDs/Cox II*-Add Celebrex® ® 400mg to the existing prior authorization list for this class.

ATTACHMENT 4.3 --continued--

- *Skeletal Muscle Relaxants*-No changes recommended.
- *Smoking Deterrent agents*-No changes recommended.
- *Triptans*-Relpax® ® to remain PDL neutral.
  - ❖ The Committee recommended that Relpax ®be re-evaluated for PDL status at their November meeting when more utilization and cost data would be available.

- DERMATOLOGICAL AGENTS-The Board approved the Therapeutics Committee's recommendations for PDL changes in the class of dermatological agents as follows:
  - *Acne/Vitamin A derivatives*-Add brand name Retin A® cream and gel to the PDL.
- ENDOCRINE AGENTS-The Board approved the Therapeutics Committee's recommendations for PDL changes in the class of endocrine agents as follows:
  - *Anti-diabetic agents*-Change Avandamet® step edit to require prior use of metformin within the past 60 days.
  - *Bone Suppression Resorption agents*-No changes recommended.
  - *Forteo*®-No changes recommended.
- GASTROINTESTINAL AGENTS-The Board approved the Therapeutics Committee's recommendations for PDL changes in the class of gastrointestinal agents as follows:
  - *H. Pylori agents*-No changes recommended.
  - *Helidac*® *and Prevpac*®-No changes recommended.
- GU AGENTS-The Board approved the Therapeutics Committee's recommendations for PDL changes in the class of GU agents as follows:
  - *BPH agents*-Add Avodart® to the PDL.
  - *Antispasmodics*-Add Oxytrol® to the PDL with a step edit for previous treatment failure with oxybutynin.
- HEMATOLOGICAL AGENTS-The Board approved the Therapeutics Committee's recommendations for PDL changes in the class of hematological agents as follows:
  - *Hematinics*-No changes recommended.
  - *Heparin and related products*-No changes recommended.
  - *Leukocyte stimulants*-No changes recommended.
  - *Platelet Aggregation Inhibitors*-No changes recommended.
- CHOLESTEROL AGENTS-The Board approved the Therapeutics Committee's recommendations for PDL changes in the class of cholesterol agents as follows:
  - *Bile Acid Sequestrants*-No changes recommended.
  - *Fibric Acids*-No changes recommended.
  - *Zetia*®-Add Zetia to the PDL with step edit. Patients with a current statin prescription may receive Zetia to augment therapy.
  - *HMG CoA Reductase Inhibitors*-Add Altocor® to the PDL.
- TOPICAL AGENTS-The Board approved the Therapeutics Committee's recommendations for PDL changes in the class of gastrointestinal agents as follows:
  - *Eye Antihistamines/Mast Cell Stabilizers*-Add Alomide® to the PDL. Remove Alamast® from the PDL.
  - *Glaucoma agents*-No changes recommended.
  - *Topical Estrogen agents*-Femring ® to remain PDL neutral and be re-evaluated in November when more utilization and cost data would be available.

ATTACHMENT 4.3 --continued--

Scott Dunham, ACS, presented the information requested at the last DUR Board meeting concerning the IBM intervention process. This included a flowchart and sample patient case for the high utilizers intervention. He also presented a tentative schedule of interventions for the months of August thru November, which would be presented individually in the future.

Ted Grissell, Health Care Excel, presented IRDP/ProDUR data for the month of July 2003. The report showed a total of 12,855 processed prior authorizations requests.

Barry Hart, Long-term Care Pharmacy Alliance, submitted public comment concerning the 90-day supply requirement for medications dispensed to Medicaid recipients. He pointed out there were other patient care settings in which patients might need exemption from this requirement. He proposed having certain types of pharmacies exempted from the 90-day supply. Dr. Smith expressed a concern that some of these residential facilities also admit family members. Mr. Hart replied that was probably the case and suggested that this issue required further study. He stated long-term care pharmacy representatives and the Indiana Pharmacists Alliance were meeting with ACS and OMPP representatives to address these issues.

SEPTEMBER 2003

Melanie Bella, OMPP Director, updated the Board on Hoosier RX and the disease state management program.

- The Hoosier RX program:
  - Included a population of over 17,000 enrollees.
  - Had three benefit levels, depending on a person's income ($500, $750, or $1,000 annual benefits). The majority of enrollees do not max out their benefits.
  - Followed the DUR Board's lead and recently implemented some drug/drug interaction and therapeutic duplication edits.
- She gave an update on their disease management program.
  - They continued to have a good response from providers and recipients.
  - OMPP was moving very aggressively with this initiative to improve quality and outcomes for recipients.
  - They have started conversations with ACS about how to utilize pharmacy claims data to augment the effectiveness of this program.
  - In July 2003, the program targeted diabetes and congestive heart failure patients in the central region of the state. That pilot program will run for 6 months.
  - In January 2004, the northern region will be added with diabetes, congestive heart failure and asthma. Asthma will be added to the central region as well.
  - In April, the southern region will be added with diabetes, congestive heart failure, and asthma. Hypertension and stroke will be added to all regions.
  - Following these implementations, a HIV-AIDS program will be added to all regions.

ATTACHMENT 4.3 --continued--

The Board asked for feedback on how they were doing in terms of being on target with cost savings. Ms. Bella responded that they were in the process of preparing a report to the legislature on the overall pharmacy program and the PDL. She hoped to have it by late fall and offered to share any completed pieces of that report with the Board.

Marc Shirley, OMPP Pharmacy Director, discussed OTC Prilosec® with the Board. He stated that there was potential for some significant cost savings to Indiana Medicaid if it were added to the OTC Drug Formulary and asked the Board for its consideration. The Board added Prilosec® OTC to the OTC Drug Formulary. The Board recommended that the Therapeutics Committee look at what impact adding OTC Prilosec® would have on the class, and report back to the Board any changes they would suggest.

Jerry Dubberly, ACS State Health Care, presented the proposed IBM and TAI initiatives for the month of October 2003.

- ACS proposed looking at narcotic utilization among patients who are receiving narcotics from three or more prescribers during a single calendar month. Since OMPP spent around $2.8 million per month for narcotic analgesics, ACS proposed to contact those physicians identified and to educate them to coordinate care and possibly eliminate any unnecessary or inappropriate prescribing of these agents. An assessment would be performed six months out looking for a change in the number of physicians who are prescribing narcotic analgesics for these patients, the number of narcotic analgesic prescriptions for these patients and a change in the cost per utilizer.

- The TAI proposal was for patients receiving concurrent therapy for multiple skeletal muscle relaxants. OMPP spent over $400,000 per month on this class of medications. There were 345 patients identified who consistently received more than two skeletal muscle relaxants for more than 2 months. The prescribing physicians would be contacted by a TAI pharmacist for a face-to-face discussion of their patient's current therapy. The goal would be to identify any inappropriate and unnecessary utilization of these medications. An assessment would be performed six months out to look for any change in the number of skeletal muscle relaxant prescriptions, the cost per utilizer and the physician response rate.
- The Board approved these initiatives for the month of October and suggested that some active follow-up to these interventions be reported back to the Board.

Issues to be addressed with articles in the next DUR Board newsletter were as follows.

- It was suggested that since ACS has the responsibility for the newsletter, it would be appropriate for them to contact Drs. Irick and Ceh for input regarding muscle relaxants.
- Reminders about appropriate antibiotic use. The MCO's are involved in an initiative in Indiana called ICARES, which stands for the Indiana Coalition for Antibiotic Resistance Education Strategies and have some literature to help promote appropriate antibiotic use.

ATTACHMENT 4.3 --continued--

Ted Grissell, Health Care Excel, presented prior authorization statistical data from the DUR productivity report for August 2003. This report showed a total of 8,530 processed prior authorizations requests and 2,079 telephone inquiries for a total of 10,609 interventions.

Dr. Lindstrom had received information from three manufacturers on new drugs.

- Glaxo SmithKline—Lamictal® has a new indication for bipolar disorder that would exempt it from prior authorization under IC 12-15-35.5. Dr. Irick commented on a Harvard study that showed there were fewer suicides in bipolar patients on lithium than other agents.
- AstraZeneca—Crestor®-a new anti-hyperlipidemic would be reviewed by the Therapeutics Committee for PDL status in November.
- Wyeth—FluMist®-a nasally administered influenza virus vaccine with strict storage and administration requirements. There was comment on whether this product should be reviewed for the PDL by the Therapeutics Committee as a prescription benefit, or be handled as a medical benefit administered in a physician's office. The Board asked that the Therapeutics Committee take up this discussion and report back their recommendations.

Dr. Lindstrom presented the PDL comparison report that would be sent to the Joint Commission on Medicaid Oversight. He felt that it was exactly what the legislature requested and thanked the Board for their considerable input over previous meetings.

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 4.4 PROVIDER BULLETINS RE: DUR PROGRAMS

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200235 JULY 8, 2002

To: **All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications**

Subject: **Implementation of Preferred Drug List—Initial Drugs**

Note: The information in this bulletin regarding prior authorization payment methodology does not apply to practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Overview and Background

Senate Enrolled Act No. 228 of the 2002 General Assembly provided for the creation and implementation of a preferred drug list (PDL) under Indiana Medicaid. Several other state Medicaid agencies are currently using, or are in various stages of implementing, a similar approach to more effectively manage their pharmacy benefits from both clinical and cost-effectiveness perspectives. A PDL approach increases the quality of pharmaceutical care by ensuring that the most clinically appropriate drug is utilized, and maximizes program funding by incentivizing the use of the most cost-effective products. Conceptually, and in accordance with law, drugs that are included on the Indiana Medicaid PDL **do not** require prior authorization, and drugs that are not included on the PDL **do** require prior authorization. Basic criteria for prior authorization requests for drugs not included on the PDL are therapeutic failure or adverse reaction with the preferred drug.

In accordance with the new law, a Medicaid Therapeutics Committee, which is a subcommittee of the state's Medicaid Drug Utilization Review (DUR) Board, was selected by the Board. The Committee, which is comprised of five physicians and two pharmacists, has the responsibility of assisting the DUR Board in the Board's development and recommendation of a PDL to the Office of Medicaid Policy and Planning. The Committee opted to first review the non-sedating antihistamines class of drugs, and at their June 12 meeting recommended certain products for PDL-inclusion. The DUR Board, at their June 21 meeting, accepted the recommendations of the Therapeutics Committee regarding non-sedating antihistamines. Those recommendations are set out in this bulletin, and constitute the first drugs to be subject to the PDL.

The PDL, with non-sedating antihistamines being the first class included thereon, is being implemented effective August 21, 2002. As of that date, all covered non-sedating antihistamines *except the ones included on the PDL* will require prior authorization. Prescribers will be notified via subsequent banner page message or bulletin of the number to call for prior authorization for non-PDL drugs.

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As additional categories of drugs are reviewed by the Therapeutics Committee and recommendations are subsequently made to the DUR Board, providers will be advised as soon as possible of additions to the PDL. OMPP is required by law to implement the changes within 30 days of the Board's recommendation, and we commit to providing as much advance notice to providers as possible, given that constraint. Currently, the Committee is scheduled to review the following classes of drugs at their next meeting (July 5): proton pump inhibitors, COX II inhibitors, ACE inhibitors, and HMG CoA reductase inhibitors. Notice of meetings of the Committee and agendas for the meetings will be posted in accordance with public notice requirements on the FSSA Web site, www.state.in.us/fssa/, under *Calendar & News* and *Calendar of Events*.

The following is effective as of August 21, 2002:

Preferred Drug List	Maximum Quantity Limitations
Allegra 30 mg	2 tablets per day
Allegra 60 mg	2 tablets/capsules per day
Allegra 180 mg	1 tablet per day
Zyrtec 1mg/ml syrup	10 ml per day

As of the same date, all other non-sedating antihistamines, including the following, are not preferred (non-preferred) and thereby require prior authorization:

Non-Preferred Drug List	
Allegra-D	Clarinex 5mg
Claritin 10mg	Zyrtec 5mg
Claritin-D 12 hour	Zyrtec 10mg
Claritin-D 24 hour	Zyrtec-D 12 hour
Claritin 10mg/10ml syrup	

Note: Prior authorization will be required for all:
1) Non-preferred drugs in this class
2) Requests for quantities of preferred drugs in this class that exceed the stated limits

We hope and anticipate that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented and further developed, and recognize and appreciate the clinical and cost effectiveness that it will bring to the Indiana Medicaid pharmacy benefit. Please bear in mind that the cost savings to be realized from the PDL approach will enable OMPP to provide for the funding of other critically needed services under Medicaid, at a time when every possible means of conserving program costs is being explored.

Please direct any questions that you have regarding this bulletin to EDS Customer Assistance at 1-800-577-1278 or (317) 655-3240. Please direct any questions about prior authorization to Health Care Excel Prior Authorization Department at (317) 347-4511, in the Indianapolis local area, or 1-800-457-4518.

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200243 AUGUST 14, 2002

To: **All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications**

Subject: **Preferred Drug List (PDL)—New Additions, Follow Up Information**

The information in this bulletin regarding prior authorization payment methodology does not apply to practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Overview and Background; New PDL Additions

As stated in a prior bulletin (*BT200235*, dated July 8, 2002), an Indiana Medicaid Preferred Drug List is being implemented effective August 21, 2002, with non-sedating antihistamines being the first class included on the list. Since the prior bulletin, the DUR Board, at their July 26 meeting, accepted the recommendations of the Therapeutics Committee regarding proton pump inhibitors (PPIs), ACE Inhibitors and Cox II inhibitors. Those recommendations are set out in this bulletin, and constitute the second group of drugs to be subject to the PDL.

As noted previously and above, PDL requirements for non-sedating antihistamines are being implemented on **August 21, 2002**. Also, as of **September 25, 2002**, all covered PPIs and ACE inhibitors *except the ones included on the PDL* will require prior authorization from ACS State Health Care at **1-866-879-0106**. Please note that since the Cox II inhibitors did not have a preferred drug added to the PDL, they will remain subject to the Indiana Rational Drug Program (IRDP) as is currently the case (see Provider bulletin *BT200148*) and, as such, require prior authorization from Health Care Excel (HCE). Phone numbers for HCE are (317) 347-4511 in the Indianapolis local area, or 1-800-457-4518 toll free.

As additional categories of drugs are reviewed by the Therapeutics Committee and recommendations are subsequently made to the DUR Board, providers will be given 30 days advance notice of additions to the PDL. The Therapeutics Committee is scheduled to review the following classes of drugs at their August 2nd meeting: calcium channel blockers (CCB), loop diuretics, beta adrenergic blocking agents, alpha adrenergic blocking agents, angiotensin receptor blockers (ARB), and platelet aggregation inhibitors. Notice of meetings of the Committee and agendas for the meetings are posted in accordance with public notice requirements on the FSSA Web site, http://www.state.in.us/fssa/, under the heading "Calendar and News". Additional information regarding the Therapeutics Committee and the PDL may be accessed at http://www.indianapbm.com/. Please also note that additional information regarding the PDL and related processes will be provided in the near future via banner page messages or bulletins.

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The following are effective as of September 25, 2002:

Preferred Drug List (PPIs)	Maximum Quantity Limitations
Protonix 40 mg	1 tablet per day
Prilosec 20 mg (Preferred for children 12 years old and under)	

As of the same date, all other proton pump inhibitors, including the following, are not preferred (non-preferred) and thereby require prior authorization:

Non-Preferred Drug List (PPIs)		
Aciphex 20 mg tablets	Prevacid 15 mg suspension	Prilosec 20 mg (For > 12 years old)
Nexium 20 mg capsule	Prevacid 30 mg capsule	Prilosec 40 mg capsule
Nexium 40 mg capsule	Prevacid 30 mg suspension	Protonix 20 mg tablets
Prevacid 15 mg capsule	Prilosec 10 mg capsule	Protonix IV 40 mg vial

Note: Prior authorization will be required for all:
1) Non-preferred drugs in this class
2) Requests for quantities of preferred drugs in this class that exceed the stated limits

Preferred Drug List (ACE Inhibitors)		
Captopril 25 mg (For children 12 years old and under)	Mavik 1mg tablet	Monopril 10 mg tablet
Captopril 50 mg (For children 12 years old and under)	Mavik 2mg tablet	Monopril 20 mg tablet
Captopril 100 mg (For children 12 years old and under)	Mavik 4mg tablet	Monopril 40 mg tablet
Lotensin 10mg tablet	Enalapril 2.5mg tablet	Enalapril 20mg tablet
Lotensin 20 mg tablet	Enalapril 5 mg tablet	
Lotensin 40 mg tablet	Enalapril 10 mg tablet	

As of the same date, all other ACE inhibitors, including the following, are not preferred (non-preferred) and thereby require prior authorization:

Non-Preferred Drug List (ACE Inhibitors)		
Accupril 5 mg tablet	Altace 1.25 mg capsule	Prinivil (generic preferred)
Accupril 10 mg tablet	Altace 2.5 mg capsule	Vasotec (generic preferred)
Accupril 20 mg tablet	Altace 5 mg capsule	Univasc 7.5 mg tablet
Accupril 40 mg tablet	Altace 10 mg capsule	Univasc 15 mg tablet
Aceon 2 mg tablet	Captopril 25 mg (For > 12 years old)	Zestril (generic preferred)
Aceon 4 mg tablet	Captopril 50 mg (For > 12 years old)	
Aceon 8 mg tablet	Captopril 100 mg (For > 12 years old)	

> *Note: Prior authorization will be required for all:*
> *1) Non-preferred drugs in this class*
> *2) Requests for quantities of preferred drugs in this class that exceed the stated limit*

We hope and anticipate that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented and further developed, and recognize and appreciate the clinical and cost effectiveness that it will bring to the Indiana Medicaid pharmacy benefit. Please bear in mind that the cost savings to be realized from the PDL approach will enable OMPP to provide for the funding of other critically needed services under Medicaid, at a time when every possible means of conserving program costs is being explored.

- **Please direct any questions that you have regardi ng this bulletin to EDS Customer Assistance at 1-800-577-1278 or (317) 655-3240.**
- **Please direct any questions about IRDP prior authorization to Health Care Excel Prior Authorization Department at (317) 347-4511, in the Indianapolis local area, or 1-800-457-4518.**
- **Please direct any questions about the PDL and prior authorization needed for non-PDL drugs to ACS State Health Care at 1-866-879-0106.**

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200246 AUGUST 26, 2002

To: **All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications**

Subject: **ACS and HCE Prior Authorization Process**

Overview and Background

As stated in prior bulletins (*BT200235*, dated July 8, 2002, and *BT200243*, dated August 8, 2002), an Indiana Medicaid Preferred Drug List (PDL) is being implemented effective August 21, 2002, with non-sedating antihistamines being the first class included on the list. Proton pump inhibitors (PPIs) and ACE inhibitors are subjected to the PDL effective September 17, 2002.

All non-sedating antihistamines, PPIs, and ACE inhibitors *except the ones included on the PDL* will require prior authorization (PA) from ACS State Healthcare at 1-866-879-0106 toll free. Please note that since the Cox II inhibitors did not have a preferred drug added to the PDL, they will remain subject to the Indiana Rational Drug Program (IRDP) as is currently the case (provider bulletin *BT200148*) and, as such, require PA from Health Care Excel (HCE). Phone numbers for HCE are (317) 347-4511 in the Indianapolis local area, or 1-800-457-4518 toll free.

As additional categories of drugs are reviewed by the Therapeutics Committee and PDL status determination is subsequently made by the Drug Utilization Review (DUR) Board, providers will be given 30 days advance notice of additions to the PDL. Notice of meetings of the DUR Board and agendas for the meetings are posted in accordance with public notice requirements on the FSSA Web site, http://www.state.in.us/fssa/, under the heading *Calendar and News*. Additional information regarding the Therapeutics Committee and the PDL may be accessed at http://www.indianapbm.com/. Please also note that additional information regarding the PDL and related processes will be provided in the near future via banner page messages or bulletins.

The summary of ACS and HCE PA Process and POS Edit Codes is listed on page 3 of this bulletin.

Therapeutic Consultation Program and PDL

Effective August 21, 2002, the PDL encompasses Indiana's clinical initiative, the Therapeutic Consultation Program (TCP). TCP is an in-bound call center in which *prescribers* call to review the member's profile for all non-preferred drugs with a TCP clinical pharmacist.

ACS and HCE Prior Authorization Process

Non-Preferred Drugs

All non-preferred drug claims will deny and post Edit 3017 at the pharmacy POS. Pharmacy providers should inform the prescriber to call the ACS State Healthcare at 1-866-879-0106 to review the non-preferred drug with a TCP pharmacist.

Preferred Drug, Exceeding Maximum Quantity Limitation

All preferred drug claims exceeding the maximum quantity limitation will deny and post Edit 3017 at the pharmacy POS. Pharmacy providers should inform the prescriber to call the ACS State Healthcare at 1-866-879-0106 to review exceeding the maximum quantity limitation with a TCP pharmacist.

Brand Medically Necessary

All drug claims associated with the PDL requiring brand medically necessary (BMN) will deny and post Edit 3017 at the pharmacy POS. Pharmacy providers should inform the prescriber to call ACS State Healthcare at 1-866-879-0106 for PA. If the drug requiring a BMN PA is also a non-preferred drug, two PAs will be needed to process the claim correctly: one PA for non-preferred and another PA for BMN. ACS will provide both PA for non-PDL and BMN for the non-preferred drug when requested together.

All drug claims **not** associated with the PDL requiring BMN will deny and post Edit 3002 at the pharmacy POS. Providers should call HCE at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518 for PA.

34-Day Supply Limit for Non-Maintenance Medications

All non-maintenance drug claims associated with the PDL requiring quantities greater than a 34-day supply will deny and post Edit 3017 and Edit 4026 at the pharmacy POS. Pharmacy providers should inform the prescriber to call the ACS State Healthcare at 1-866-879-0106 for PA. As with BMN, two distinct PAs will be required for claim approval, one for the PDL and one for the 34 day supply limitation. PA will not be granted unless an extenuating circumstance exists to substantiate the need to dispense greater than a 34-day supply of the product.

All non-maintenance drug claims **not** associated with the PDL requiring quantities greater than a 34-day supply will deny and post Edit 4026 at the pharmacy POS. Providers should call HCE at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518 for PA. Prior authorization will not be granted unless an extenuating circumstance exists to substantiate the need to dispense greater than 34-days supply of the product.

All IRDP therapy exceeding limitation will deny and post 6806 at the pharmacy POS. Providers should call HCE at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518 for PA.

Prospective Drug Utilization Review Alerts (ProDUR)

All ProDUR PA requests (Early Refill Edit 0570, High Dose Edit 0571, Therapeutic Duplication Edit 0572, Drug/Drug Interaction Edit 0573) should be referred to HCE at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

Emergency Supply

In instances where PA cannot be immediately obtained, a pharmacist may dispense a 72-hour supply of a covered prescription drug and will be reimbursed by the IHCP if, subsequent to dispensing in an emergent situation, indication is made on the claim that the supply is for an emergency need.

POS Edit Codes

Edit 3017	**PDL/Non-preferred drugs** **BMN associated with PDL**	**Call ACS**	**1-866-879-0106**
Edit 3002	**IRDP**	**Call HCE**	**(317) 347-4511** **1-800-457-4518**
Edit 4026	**NDC/ Days Supply Limitation**	**Call HCE**	**(317) 347-4511** **1-800-457-4518**
Edit 0570	**Refill too soon**	**Call HCE**	**(317) 347-4511** **1-800-457-4518**
Edit 6806	**IRDP** **Therapy exceeds limitation**	**Call HCE**	**(317) 347-4511** **1-800-457-4518**

We hope and anticipate that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented and further developed; and recognize and appreciate the clinical and cost effectiveness that it will bring to the Indiana Medicaid pharmacy benefit. Please bear in mind that the cost savings to be realized from the PDL approach will enable the OMPP to provide for the funding of other critically needed services under Medicaid, at a time when every possible means of conserving program costs is being explored.

- **Please direct any questions that you have regarding this bulletin to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.**
- **Please direct any questions about IRDP PA to HCE PA Department at (317) 347-4511, in the Indianapolis local area, or 1-800-457-4518.**
- **Please direct any questions about the PDL and PA needed for non-PDL drugs to ACS State Health Care at 1-866-879-0106.**

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200247 SEPTEMBER 9, 2002

To: **All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications**

Subject: **Preferred Drug List—New Additions (Phase 3)**

Note: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system

New PDL Additions

With Phase 1 of the Indiana Medicaid Preferred Drug List (PDL) implementation on August 21, 2002, (reference bulletin *BT200235*) and Phase 2 on September 17, 2002, (reference bulletin *BT200243*), this bulletin serves to notify you of Phase 3 of the PDL effective October 9, 2002. The Drug Utilization Review (DUR) Board accepted the PDL recommendations of the Therapeutics Committee at the Board's meeting on August 16, 2002, for the following therapeutic classes:

- Calcium Channel Blockers
- Loop Diuretics
- Beta Adrenergic Blocking Agents
- Alpha Adrenergic Blocking Agents
- Platelet Aggregation Inhibitors

Notice of meetings of the DUR Board and agendas are posted on the Family and Social Services Administration (FSSA) Web site, http://www.state.in.us/fssa/, under the heading *Calendar and News*. Information regarding the Therapeutics Committee and the PDL may be accessed at http://www.indianapbm.com.

Therapeutic Consultation Program and PDL

The Therapeutic Consultation Program (TCP) is an in-bound call center in which *prescribers* call to review the member's profile for all non-preferred drugs (non-PDL) with a TCP clinical pharmacist. The TCP hours of operation are from 8 am – 6 pm Indianapolis time, Monday through Friday. To assist the dispensing pharmacist, a summary of the prior authorization (PA) process and point of service (POS) Edit codes is listed in the table below. For a more thorough explanation please refer to provider bulletin *BT200246*.

POS Edit Codes			
Edit 3017	PDL/Non-preferred drugs Brand Medically Necessary associated with PDL	Call ACS	1-866-879-0106
Edit 3002	Indiana Rationale Drug Program	Call HCE	(317) 347-4511 1-800-457-4518
Edit 4026	NDC/Days Supply Limitation	Call HCE	(317) 347-4511 1-800-457-4518
Edit 0570	Refill too soon	Call HCE	(317) 347-4511 1-800-457-4518
Edit 6806	IRDP Therapy exceeds limitation	Call HCE	(317) 347-4511 1-800-457-4518

The Following Are Effective as of October 9, 2002:

Preferred Drug List (Calcium Channel Blockers)	Non-Preferred Drug List (Calcium Channel Blockers)
Adalat CC 90mg tablets	Adalat 10mg, 20mg capsules
Covera-HS 180mg, 240mg tablets	*Adalat CC 30mg, 60mg tablets
Diltiazem (all strengths and formulations)	*Calan (all strengths)
DynaCirc (all strengths)	*Cardene 20mg, 30mg capsules
Nicardipine (all generic strengths)	Cardene SR 30mg, 45mg, 60mg capsules
Nifedipine (all sustained release products)	*Cardizem (all strengths)
Nimotop 30mg capsules	*Dilacor XR 120mg, 180mg, 240mg capsules
Norvasc (all strengths)	*Isoptin (all strengths)
Plendil (all strengths)	Nifedipine (short acting) 10mg, 20mg capsules
Sular (all strengths)	Procardia 10mg, 20mg capsules
Tiazac (all strengths)	*Procardia XL 30mg, 60mg, 90mg tablets
Verapamil (all strengths and formulations)	Vascor 200 mg, 300mg tablets
Verelan PM 100mg, 200, 300mg capsules	*Verelan 120mg, 180mg, 240mg, 360mg capsules

**Please note that Brand products are considered Non-Preferred if a generic equivalent is available and is listed above in the Non-PDL. Thus, generic equivalents listed in the PDL will not require PA.*

Preferred Drug List (Loop Diuretics)	Non-Preferred Drug List (Loop Diuretics)
Bumetanide (all strengths and formulations)	*Bumex 0.5 mg, 1mg, 2mg tablets
Furosemide (all strengths and formulations)	*Demadex 5mg, 10mg, 20mg, 100mg tablets
Torsemide (all strengths and formulations)	Edecrin 25mg, 50mg tablets
	*Lasix 20mg, 40mg, 80mg tablets

**Please note that brand products are considered Non-Preferred if a generic equivalent is available and is listed above in the Non-PDL. Thus, generic equivalents listed in the PDL will not require PA.*

Preferred Drug List (Beta Adrenergic Blocking Agents)	Non-Preferred Drug List (Beta Adrenergic Blocking Agents)
Acebutolol (all strengths)	*Betapace 80mg, 120mg, 160mg, 240mg tablets
Atenolol (all strengths)	Betapace AF 80mg, 120mg, 160mg tablets
Betaxolol 10mg, 20mg tablets	*Blocadren 5mg, 10mg, 20mg tablets
Bisoprolol (all strengths)	Cartrol 2.5mg, 5mg tablets
Inderal - LA (all LA strengths)	†Coreg 3.125mg, 6.25mg, 12.5mg, 25mg tablets
Labetalol (all strengths and formulations)	*Corgard 20mg, 40mg, 80mg, 120mg, 160mg tablets
Metoprolol (all strengths and formulations)	*Inderal 10mg, 20mg, 40mg, 60mg, 80mg tablets
Nadolol (all strengths)	*Kerlone 10mg, 20mg tablets
Pindolol (all strengths)	Levatol 20mg tablets
Propranolol (all strengths and formulations)	*Lopressor 50 mg, 100mg tablets
Sotalol 80mg, 120mg, 160mg, 240mg, tablets	*Normodyne 100mg, 200mg, 300mg tablets
Timolol 5mg, 10mg, 20mg tablets	*Sectral 200mg, 400mg capsules
Toprol XL 25mg, 50mg, 100mg, 200mg tablets	*Tenormin 25mg, 50mg, 100mg tablets
	*Trandate 100mg, 200mg, 300mg tablets
	*Visken 5mg, 10mg tablets
	*Zebeta 5 mg, 10mg tablets

**Please note that brand products are considered Non-Preferred if a generic equivalent is available and is listed above in the Non-PDL. Thus, generic equivalents listed in the PDL will not require PA.*

*† Please note that patients currently on Coreg **will not** be subjected to the Non-PDL Edit.*

Preferred Drug List (Alpha Adrenergic Blocking Agents)	Non-Preferred Drug List (Alpha Adrenergic Blocking Agents)
Doxazosin (all strengths)	*Cardura 1mg, 2mg, 4mg, 8mg tablets
Prazosin (all strengths)	*Hytrin 1mg, 2mg, 5mg, 10mg
Terazosin (all strengths)	*Minipress 1 mg, 2mg, 5mg

**Please note that brand products are considered Non-Preferred if a generic equivalent is available and is listed above in the Non-PDL. Thus, generic equivalents listed in the PDL will not require PA.*

Preferred Drug List (Platelet Aggregation Inhibitors)	Non-Preferred Drug List (Platelet Aggregation Inhibitors)
Plavix 75 mg tablets	Aggrenox capsules
Pletal 50 mg, 100 mg tablets	Ticlid 250 mg tablets
	Ticlopidine 250 mg tablets

We hope and anticipate that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented and further developed, and recognize and appreciate the clinical and cost effectiveness that it will bring to the Indiana Medicaid pharmacy benefit. Please bear in mind that the cost savings to be realized from the PDL approach will enable the Office of Medicaid Policy and Planning (OMPP) to provide for the funding of other critically needed services under Medicaid, at a time when every possible means of conserving program costs is being explored.

- Please direct any questions that you have regarding this bulletin to EDS Customer Assistance at (317) 655-3240 or 1-800-577-1278.
- Please direct any questions about PA to Health Care Excel PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.
- Please direct any questions about the PDL and PA needed for non-PDL drugs to ACS State Health Care at 1-866-879-0106.

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200255 NOVEMBER 11, 2002

To: **All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications**

Subject: **Preferred Drug List—New Additions (Phases 4 and 5)**

Note: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system

Overview and Background

As stated in a previous bulletin (*Bulletin BT200247*, dated September 9, 2002), an Indiana Health Coverage Programs (IHCP) Preferred Drug List (PDL) is being implemented. The program began August 21, 2002, with non-sedating antihistamines as the first class on the list. The Drug Utilization Review (DUR) Board, at its September 20, 2002, (Phase 4) meeting, accepted the recommendations of the Therapeutics Committee regarding inhaled corticosteroids, short and long acting beta agonists, nasal corticosteroids, leukotriene inhibitors, and HMG COA reductase inhibitors. At its October 18, 2002, (Phase 5) meeting, the DUR Board accepted the recommendations of the Therapeutics Committee regarding triptans, thiazolidenediones, ACEI/CCB combinations, ACEI with diuretics, ARBs with diuretics, and BPH medications. The recommendations from both meetings are in this bulletin and constitute the fourth and fifth groups of drugs to be subject to the PDL.

The Therapeutics Committee recommends drugs for the PDL after extensive clinical review. The OMPP hopes and anticipates that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented and further developed, and recognize and appreciate the clinical and cost effectiveness that it will bring to the IHCP.

Note: Prior authorizations (PAs) assigned under the current Indiana Rational Drug Program clinical programs will bypass PDL edits until those PAs expire. Existing PAs for brand medically necessary *will likewise be honored through the assigned* through *date of the PA.*

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Phase 4 PDL Additions

The following are effective as of December 10, 2002:

Preferred Drug List (Inhaled Corticosteroids)	Non-Preferred Drug List (Inhaled Corticosteroids)
Triamcinolone (Azmacort®)	Fluticasone (Flovent® 220 mcg)
Budesonide (Pulmicort Turbohaler® and Respules®) The Pulmicort Turbohaler® is for members more than six years old with a limit of one canister per month. Pulmicort Respules are restricted to members six years old or younger.	Fluticasone (Flovent Rotadisk®)
Fluticasone (Flovent® 44mcg and 110mcg)	Beclomethasone (Becolvent®, Vanceril®, Vanceril DS®)
Beclomethasone dipropionate HFA (Qvar®)	Flunisolide (AeroBID®, AeroBID M®)
Fluticasone/Salmeterol (Advair®)	

Preferred Drug List (Short Acting Beta Agonists)	Non-Preferred Drug List (Short Acting Beta Agonists)
Albuterol	Levalbuterol (Xopenex®)
	Bitolterol (Tornalate®)
	Metaproteranol (Alupent®, Prometa®)
	Pibuterol (MaxAir®)
	Terbutaline (Brethine®)
	Proventil®, Proventil HFA ®, Ventolin®, (Brand)*

Preferred Drug List (Long Acting Beta Agonists)	Non-Preferred Drug List (Long Acting Beta Agonists)
Salmeterol (Serevent®)	Formeterol (Foradil®)

Preferred Drug List (Nasal Corticosteroids)	Non-Preferred Drug List (Nasal Corticosteroids)
Azelastine (Astelin®)	
Beclomethasone (Beconase®, Beconase AQ®, Vancenase®, Vancenase®, Vancenase AQ DS®)	
Flunisolide (Nasalide®and Nasarel®)	
Fluticasone (Flonase®)	
Triamcinolone (Nasacort®, Nasacort AQ®, Tri-Nasal®)	
Budesonide (Rhinocort®, Rhinocort AQ®)	
Mometasone (Nasonex®)	

Preferred Drug List (Leukotriene Inhibitors)	Non-Preferred Drug List (Leukotriene Inhibitors)
Montelukast (Singulair®)	Zileuton (ZyFlo®)
Zafirlukast (Accolate®)	

Preferred Drug List (HMG CoA Reductase Inhibitors)	Non-Preferred Drug List (HMG CoA Reductase Inhibitors)
Atorvastatin (Lipitor®)	Extended release lovastatin (Altocor®)
Fluvastatin (Lescol®, Lescol XL®)	Niacin/Lovastatin (Advicor®)
Pravastatin (Pravachol®)-for patients receiving HIV antiretroviral therapy	Mevacor® (Brand)*
Simvastatin (Zocor®)	
All forms of generic lovastatin	

**Please note that the brand products on the non-PDL with generic equivalents on the PDL are considered non-preferred. These generic equivalents do not require PA for non-PDL edits.*

Phase 5 PDL Additions

The following are effective as of December 10, 2002:

Preferred Drug List (Triptans)	Non-Preferred Drug List (Triptans)
Sumatriptan (Imitrex®) 25, 50, 100mg tablets: limited to one box (9 tablets) per month	Naratriptan (Amerge®)
Sumatriptan (Imitrex®) 5, 20mg nasal spray: limited to 1 box (6 inhalers, 6mls) per month	Frovatriptan (Frova®)
Sumatriptan (Imitrex®) stat dose refill: limited to 1 box (2 injections) per month	Rizatriptan (Maxalt®, Maxalt MLT®)
Sumatriptan (Imitrex®) vial: limited to 2 vials (2 injections per month)	Zolmitriptan (Zomig®, Zomig ZMT®)
Almotriptan (Axert®) tablets: limited to one box (6 tablets) per month	

Preferred Drug List (Thiazolidenediones)	Non-Preferred Drug List (Thiazolidenediones)
Pioglitazone (Actos®) 15mg only: limited to 90 tablets per month	Pioglitazone (Actos®) 30 and 45mg
Rosiglitazone (Avandia®) 4 and 8mg: limited to 30 tablets per month	Rosiglitazone (Avandia®) 2mg

Preferred Drug List (ACEIs with CCB)	Non-Preferred Drug List (ACEIs with CCB)
Amlodipine/Benazepril (Lotrel®): limited to 30 tablets per month	Trandolapril/Verapamil (Tarka®)
	Felodipine/Enalapril (Lexxel®)

Preferred Drug List (ACEIs with Diuretics)	Non-Preferred Drug List (ACEIs with Diuretics)
Lisinopril/HCTZ	Quinapril/HCTZ (Accuretic®)
Captopril/HCTZ	Capozide® (Brand)*
Enalapril/HCTZ	Prinzide® (Brand)*
Fosinopril/HCTZ (Monopril HCT®)	Zestorectic® (Brand)*
Benazepril/HCTZ (Lotensin HCT®)	Vaseretic® (Brand)*

Preferred Drug List (ARBs with Diuretics)	Non-Preferred Drug List (ARBs with Diuretics)
Losartan/HCTZ (Hyzaar®)	Candesartan/HCTZ (Atacand HCT®)
Telmisartan/HCTZ (Micardis®)	Irbesartan/HCTZ (Avalide®)

Preferred Drug List (BPH)	Non-Preferred Drug List (BPH)
Talmsulosin (Flomax®)	
Finasteride (Proscar ®)	

**Please note that the brand products on the non-PDL with generic equivalents on the PDL are considered non-preferred. These generic equivalents do not require PA for non-PDL edits.*

Effective December 10, 2002, inhaled corticosteroids, short and long acting beta agonists, nasal corticosteroids, leukotriene inhibitors, and HMG COA reductase inhibitors, and on that same date triptans, thiazolidenediones, ACEI/CCB combinations, ACEI with diuretics, ARBs with diuretics, and BPH medications not on the PDL will require PA from ACS State Health Care at 1-866-879-0106.

Please note that in accordance with Indiana law, all anti-anxiety, antidepressant, anti-psychotic, and cross-indicated drugs are considered as being on the PDL..

Note: Prior authorization will be required for all:
1) Non-preferred drugs in a class
2) Requests for quantities of preferred drugs in a class that exceed the stated limit

- Please direct any questions about this bulletin to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.
- Please direct any questions about PA to the Health Care Excel PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.
- Please direct any questions about the PDL and PA needed for non-PDL drugs to ACS State Health Care at 1-866-879-0106.

Edit Code	Description	Contact Name	Contact Number
3017	PDL/Non-PDL Brand Med Necessary associated with PDL/Non-PDL	ACS	1-866-879-0106
3002	IRDP – Indiana Rational Drug Program	HCE	(317) 347-4511 1-800-457-4518
4026	NDC/Days Supply Limits	HCE	(317) 347-4511 1-800-457-4518
0570	Refill too Soon	HCE	(317) 347-4511 1-800-457-4518
6806	IRDP Therapy exceeds limitation	HCE	(317) 347-4511 1-800-457-4518

As additional categories of drugs are reviewed by the Therapeutics Committee and recommendations are subsequently made to the DUR Board, providers will be given at least 30 days advance notice of additions to the PDL. The Therapeutics Committee is scheduled to review the following classes of drugs at the November 1, 2002, meeting: Macrolides (W1D), Quinolones (W1Q), Cephalosporins, 2nd & 3rd generations (W1X & W1Y), Antifungals (W3B).

Notice of meetings of the Therapeutics Committee and agendas for the meetings are posted in accordance with public notice requirements on the Family and Social Services Administration (FSSA) Web site at http://www.state.in.us/fssa under the heading *Calendar and News*. Additional information regarding the Therapeutics Committee and the PDL may be accessed at http://www.indianapbm.com. Please also note that additional information regarding the PDL and related processes will be provided in the near future via banner page messages or bulletins.

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200261 DECEMBER 6, 2002

To: **All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications**

Subject: **Preferred Drug List—New Additions (Phase 6)**

Note: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system

Overview

As stated in a previous bulletin (*BT200235*, dated June 28, 2002), an Indiana Health Coverage Programs (IHCP) Preferred Drug List (PDL) is being implemented. The PDL is scheduled to be completed in April 2003. A complete list of current preferred drugs is available on the Web at www.Indianapbm.com. At its November 15, 2002, (Phase 6) meeting, the Drug Utilization Review (DUR) Board accepted the recommendations of the Therapeutics Committee regarding macrolides, fluoroquinolones, cephalosporins, antifungals, and angiotensin receptor blockers (ARBs). The recommendations from the meeting are set out in this bulletin and constitute the sixth group of drugs to be subject to the PDL.

The Therapeutics Committee was very concerned about the current problem of bacterial resistance to antibiotics and that limiting drug choice would worsen this problem. Consequently, all macrolides and fluoroquinolones were included on the PDL. The committee elected to include all generically available first- and second-generation cephalosporin products on the PDL as well as two third-generation agents for the treatment of resistant organisms and to expand the spectrum of bacterial coverage. In the antifungal class, fluconazole was selected for the PDL because it possesses desirable pharmacologic properties. It is important to note that only systemic antifungal agents were included in this review. Other antifungal agents that have indications for topical infections will be reviewed at a later time. The Therapeutics Committee felt that the clinical merits and prevention of further bacterial resistance outweighed the cost of these drug classes.

Important Information

1. **Effective March 2003, refills will not be permitted for any antibiotic prescription without the appropriate ICD-9 code written on the prescription.**
   - Appropriate ICD-9 codes include diagnoses such as but not limited to: chronic otitis media, chronic UTI, prostatitis, chronic bronchitis, chronic sinusitis, cystic fibrosis, and so forth.
   - Prescriptions coded with the appropriate ICD-9 code will not require prior authorization.
2. **Beginning January 2003, all antibiotic products packaged in a unit dose pack (such as Z-PAK) will be limited to one pack per month.**

3. Beginning January 2003, all fluoroquinolones will be limited to a 14-day supply.

Phase 6 PDL Additions

The following are effective January 7, 2003:

Note: ICD-9 codes will be required beginning in March 2003 for refills for antibiotics.

Preferred Drug List (Macrolides)	Non-Preferred Drug List (Macrolides)
Zithromax® (azithromycin): Note: More than one Z-PAK® per month will require prior authorization	Brand erythromycin products*
Biaxin® (clarithromycin): Note: More than one Biaxin XL PAC® per month will require prior authorization	
Dynabac® (dirithromycin): Note: More than one D-5 PAC® per month will require prior authorization	
Erythromycin generic products	

Preferred Drug List (Fluoroquinolones)	Non-Preferred Drug List (Fluoroquinolones)
Cipro® (ciprofloxacin)	
Tequin® (gatifloxacin): Note: More than one TEQ-PAC® per month will require prior authorization	
Levaquin® (levofloxacin)	
Maxaquin® (lomefloxacin)	
Avelox® (moxifloxacin): Note: More than one ABC PAC® per month will require prior authorization	
Noroxin® (norfloxacin)	
Floxin® (ofloxacin)	
Zagam® (sparfloxacin)	

Preferred Drug List (Cephalosporins)	Non-Preferred Drug List (Cephalosporins)
All generic first and second generation cephalosporins	Ceftin® brand*
Omnicef® (cefdinir)	Ceclor® brand*
Suprax® (cefixime)	Cefzil® (cefprozil)
	Lorabid® (loracarbef)
	Vantin® (cefpodoxime)
	Cedax® (ceftibuten)
	Spectracef® (cefditoren)

Preferred Drug List (Antifungals)	Non-Preferred Drug List (Antifungals)
Diflucan® (fluconazole) all doses and all formulations: Diflucan 150 mg is limited to two tablets every fourteen days.	Nizoral® brand*
Ketoconazole generic products	Sporanox® (itraconazole)
	Lamisil® (terbinafine)
	Vfend® (voriconazole)

Preferred Drug List (ARBs) **This class must go through the ACEI step edit process. Patients must have failed an ACEI within the previous year.**	Non-Preferred Drug List (ARBs)
Cozaar® (losartan): Limited to 1 tablet per day	Atacand® (candesartan)
Micardis® (telmisartan): Limited to 1 tablet per day	Avapro® (irbesartan)
	Diovan® (valsartan)
	Benicar® (olmesartan)
	Teveten® (eprosartan)

*When a brand name drug having generic equivalents is included in the *Non-Preferred Drug List* listing, please note that the generic equivalents for the brand name drug are considered as being **on** the PDL, and therefore do not require prior authorization.

Note: In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and cross indicated *drugs are considered as being on the PDL.*

Effective January 7, 2003, macrolides, fluoroquinolones, cephalosporins, antifungals, and ARBs not on the PDL will require prior authorization from ACS State Healthcare at 1-866-879-0106.

Note: Prior authorization will be required for all:
1) Non-preferred drugs in a class
2) Requests for quantities of preferred drugs in a class that exceed the stated limit

Clarification

The previous preferred drug list recommendations for the short-acting beta agonists were stated in IHCP bulletin *BT200255*, dated November 11, 2002. All formulations of generic albuterol are considered preferred. Please note that albuterol inhalers are limited to three canisters per month for individuals younger than 19 years old, and two canisters per month for individuals 19 years old and older.

Further Information

- Please direct any questions about the PDL and PA needed for non-PDL drugs to ACS State Health Care at 1-866-879-0106.
- Please direct any questions about this bulletin to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.
- Please direct any questions about PA to the Health Care Excel PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

Edit Code	Description	Contact Name	Contact Number
3017	PDL/Non-PDL Brand Med Necessary associated with PDL/Non-PDL	ACS	1-866-879-0106
3002	IRDP – Indiana Rational Drug Program	HCE	(317) 347-4511 1-800-457-4518
4026	NDC/Days Supply Limits	HCE	(317) 347-4511 1-800-457-4518
0570	Refill too soon	HCE	(317) 347-4511 1-800-457-4518
6806	IRDP Therapy exceeds limitation	HCE	(317) 347-4511 1-800-457-4518

As additional categories of drugs are reviewed by the Therapeutics Committee, and recommendations are subsequently made to the DUR Board, providers will be given 30 days advance notice of additions to the PDL.

The Therapeutics Committee is scheduled to review the following classes of drugs at the December 6, 2002, meeting:

- Bone resorption suppression agents (P4L)
- SERMs (V1T)
- Heparin and related products (M9K)
- Antiemetic and antivertigo agents (H6L)

Notice of meetings of the Therapeutics Committee and agendas for the meetings are posted in accordance with public notice requirements on the FSSA Web site at http://www.state.in.us/fssa, under the heading, *Calendar and News*. Additional information about the Therapeutics Committee and the PDL may be accessed at http://www.indianapbm.com. Please also note that additional information about the PDL and related processes will be provided in the near future via banner page messages or bulletins.

PROVIDER BULLETIN

BT200306 JANUARY 22, 2003

To: All Pharmacy Providers and Prescribing Practitioners

Subject: Implementation of High Dose ProDUR Alerts

Note: The information referenced below is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

Overview

The bulletin announces the implementation of prior authorization for high dose Prospective Drug Utilization Review (ProDUR) alerts effective March 6, 2003. The following is the description of the high dose ProDUR alerts published in provider bulletin *BT200221*, dated May 15, 2002: "High dose has been defined by the Indiana DUR Board as a dose that exceeds the maximum daily dosage based on criteria published by First DataBank." All applicable claims will post a high dose edit *0571-High dose*, if the submitted dose exceeds the First DataBank maximum daily dosage. Prior authorization (PA) will be required for all therapeutic classes and/or drugs unless noted below. The dispensing pharmacist can obtain PA through Health Care Excel (HCE) when a dose exceeds the First DataBank maximum daily dosage.

Prior Authorization

The PA process will involve the following elements:

- Claim verification
- Maximum daily dose information
- Confirmation of professional communication between the pharmacist and the prescriber

Exemptions

At this time, the following are the only drugs exempt because the Indiana Rational Drug Program screens them:

- Hydrocodone/APAP
- Oxycodone/APAP
- Oxycodone

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Overrides

The dispensing pharmacist can continue to override the following therapeutic classes and drugs at the point-of-sale (POS) without obtaining PA:

- J5D Beta-Adrenergic Agents
- Q8B Ear Preparations, Misc. Anti-infectives
- Q8W Ear Preparations, Antibiotics
- Q8H Ear Preparations, Local Anesthetics
- Q6I Eye Antibiotic-Corticoid Combinations
- Q6R Eye Antihistamines
- Q6P Eye Anti-inflammatory Agents
- Q6V Eye Antivirals
- Q6H Eye Local Anesthetics
- Q6S Eye Sulfonamides
- Q6C Eye Vasoconstrictors (RX Only)
- Q6G Miotics/Other Intraoc. Pressure Reducers
- H2A Central Nervous System Stimulants
- J1B Cholinesterase Inhibitors
- Guanfacine HCl
- Clonidine HCl
- H2H, H7L, H7K, H7J Monoamine Oxidase (MAO) Inhibitors
- H2E, H2Q Sedative-Hypnotics, Non-Barbiturate
- H2S, H7H Serotonin Specific Reuptake Inhibitor
- H7E Serotonin-2 Antagonist/Reuptake Inhibitors
- H7C Serotonin-Norepinephrine Reuptake-Inhibit
- H2X Tricyclic Antidepressant/Benzodiazepine Combinations
- H2W Tricyclic Antidepressant/Phenothiazine Combinations
- H2U Tricyclic Antidepressants & Rel. Non-Sel. Reuptake Inhibitors
- H2L, H2O Anti-Psychotics, Non-Phenothiazines
- H2G, H2I Anti-Psychotics, Phenothiazines
- H4B, H4C Anticonvulsants
- H7P Antipsychotics, Dopamine, & Serotonin Antagonists
- H2D Barbiturates
- A9A Calcium Channel Blocking Agents
- Q6W Ophthalmic Antibiotics
- Q6U Ophthalmic Mast Cell Stabilizers

- Q6A Ophthalmic Preparations, Miscellaneous
- H2F, H2P Anti-Anxiety Drugs
- H2M Anti-Mania Drugs
- H2V Anti-Narcolepsy/Anti-Hyperkinesis Agents

The Office of Medicaid Policy and Planning (OMPP) along with the Indiana Health Coverage Programs (IHCP) DUR Board will review the override rate of the high dose alerts, as well as the types of drugs that post the alert to determine the need to exempt additional drugs from POS claim denial or allow a pharmacist to override the alert. The applicable POS edit code is *0571-High dose*. Providers will be notified separately of any exceptions to the high dose override policy.

Emergency Situations

In instances where PA cannot be immediately obtained, *42 U.S.C. § 1396r-8* provides for dispensing of a 72-hour supply of a covered prescription drug in an emergency situation. Pharmacists who dispense a 72-hour supply of a covered prescription drug will be reimbursed by the IHCP if, subsequent to dispensing in an emergency, indication is made on the claim that the supply was a necessary emergency.

Additional Information

Refer questions about this policy to HCE Prior Authorization Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

PROVIDER BULLETIN

BT200307 JANUARY 27, 2003

To: All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications

Subject: Preferred Drug List—New Additions (Phase 7)

> *Note: The information in this bulletin regarding prior authorization payment methodology does not apply to practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.*

Overview

This bulletin announces the Indiana Health Coverage Programs (IHCP) Preferred Drug List (PDL) Phase 7 implementation. The PDL is scheduled for completion in April 2003. A complete list of current preferred drugs is available on the Web at www.Indianapbm.com. At the Drug Utilization Review (DUR) Board meeting December 20, 2002, the following medications were recommended by the Therapeutics Committee and approved by the DUR Board:

- Medications used in treating osteoporosis (Selective Estrogen Receptor Modulators – SERMs/Bone Resorption Suppression Agents)
- Heparin and related preparations
- Antiemetic/Antivertigo Agents

The approvals from the DUR Board meeting are contained in this bulletin and constitute the seventh group of drugs subject to the PDL.

The Therapeutics Committee was concerned about the morbidity associated with osteoporosis. The committee felt that Evista® was an important agent for patients intolerant to biphosphonates. Additionally, the committee acknowledged that biphosphonates did have clinical merit but no clinical difference has been established between the agents. Actonel® was chosen as the drug of choice to treat Paget's disease of bone because patients respond to this therapy more quickly. The Therapeutics Committee felt that the clinical merits and prevention of further clinical and economic burdens outweighed the cost of this drug class.

The Therapeutics Committee considered the clinical efficacy, safety, and cost of the heparin, and related products. The committee felt the selected products are the most clinically and cost effective agents and commented on the importance of encouraging the use of Fragmin® where indicated because the agent is dosed once daily.

The committee also reported on the clinical significance of the antiemetic/antivertigo agents. Anzemet® was not selected because of the adverse cardiac risk profile and lack of utilization. Furthermore, the committee suggested that limits could help facilitate appropriate use of this drug class, and suggested a utilization review in six months.

The Therapeutics Committee recommends drugs for the PDL after extensive clinical review. The IHCP anticipates that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented or further developed. The IHCP recognizes and appreciates the clinical and cost effectiveness that the PDL brings . It is important to note that the cost savings realized from the PDL program will enable the OMPP to fund other critically needed services under the IHCP .

Phase 7 PDL Additions

The following PDL Phase 7 additions are effective **February 26, 2003:**

Table 1 – SERMS/Bone Resorption Suppression Agents

Preferred Drug List (SERMs/Bone Resorption Suppression Agents)	Non-Preferred Drug List (SERMs/Bone Resorption Suppression Agents)
Actonel® (risedronate) all formulations	Didronel® brand products
Evista® (raloxifene)	Fosamax® QD formulations
Etidronate disodium generic products	Miacalcin® (calcitonin-salmon)
Fosamax® (alendronate) weekly formulations	Skelid® (tiludronate)

Table 2 – Heparin and Related Products

Preferred Drug List (Heparin and related products)	Non-Preferred Drug List (Heparin and related products)
Fragmin® (dalteparin): pre-filled syringes only	Arixtra® (fondaparinux)
Heparin: all generic formulations	Fragmin® (dalteparin): formulations other than pre-filled syringes
Lovenox® (enoxaparin): pre-filled syringes only	Innohep® (tinzaparin)
	Lovenox® (enoxaparin): formulations other than pre-filled syringes

Table 3 – Antiemetic/Antivertigo Agents

Preferred Drug List (Antiemetic/Antivertigo Agents)	Non-Preferred Drug List (Antiemetic/Antivertigo Agents)
Kytril® (granisetron): limited to 10 tablets per prescription	Anzmet® (dolasetron): limited to 10 tablets per prescription
Zofran® (ondansetron): limited to 10 tablets per prescription for all tablet formulations and 1 bottle of oral solution per prescription	

*Note: *When a brand name drug having generic equivalents is included in the "Non-Preferred Drug List" listing, please note that the generic equivalents for the brand name drug are considered as being ON PDL and therefore do not require prior approval.*

Effective **February 26, 2003**, SERMs/Bone Resorption Suppression Agents, Heparin (and related products) and Antiemetic/Antivertigo Agents not on the PDL will require prior authorization from ACS State Health Care at *1-866-879-0106*. Additionally, any antiemetic/antivertigo agents (PDL or non-PDL) exceeding quantity limits will also require a prior authorization.

> *Note: Prior authorization will be required for all non-preferred drugs in a class and requests for quantities of preferred drugs in a class that exceed the stated limit.*

Table 4 – Contact List

3017	PDL / Non-PDL Brand Med Necessary associated with PDL / Non-PDL	ACS	1-866-879-0106
3002	IRDP – Indiana Rational Drug Program	HCE	(317) 347-4511 1-800-457-4518
4026	NDC/ Days Supply Limits	HCE	(317) 347-4511 1-800-457-4518
0570	Refill too Soon	HCE	(317) 347-4511 1-800-457-4518
6806	IRDP Therapy exceeds limitation	HCE	(317) 347-4511 1-800-457-4518

The following classes of drugs were reviewed by the Therapeutics Committee at the January 3 meeting: leukocyte (WBC) stimulants, hematinics, and smoking deterrent agents. As the Therapeutics Committee reviews additional drug categories and recommendations are made to the DUR Board, providers will be given 30 days notice of additions to the PDL in future banner page articles or bulletins.

Additional Information

Notice of the Therapeutics Committee meetings and agendas for the meetings are posted in accordance with public notice requirements on the FSSA Web site, http://www.state.in.us/fssa, by clicking on Calendar and News. Additional information about the Therapeutics Committee and the PDL can be accessed at http://www.indianapbm.com.

Direct questions about this bulletin to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. Direct questions about prior authorization to Health Care Excel Prior Authorization Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518. **Direct questions about the PDL and prior authorization needed for non-PDL drugs to ACS State Health Care at 1-866-879-0106.**

PROVIDER BULLETIN

BT200319 MARCH 28, 2003

To: All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications

Subject: Preferred Drug List—New Additions (Phase 8)

Note: The information in this bulletin does not apply to practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Overview

As stated in the Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200247*, dated September 9, 2002, a Preferred Drug List (PDL) is being implemented for the fee-for-service benefits within the IHCP. The PDL is scheduled for completion in April 2003. A complete list of current preferred drugs is being compiled and will be made available on the Web at www.Indianapbm.com. The Drug Utilization Review (DUR) Board, at the February 21, 2003, Phase 8 meeting, approved PDL recommendations from the Therapeutics Committee for the following drug classes:

- Bile Acid Sequestrants
- Fibric Acids
- Skeletal Muscle Relaxants
- Urinary Tract Antispasmodics
- Brand Name Narcotics*
- Antidiabetic Agents.

**Note: The transition of certain Indiana Rational Drug Program (IRDP) products to the Preferred Drug List.*

Notice of meetings of the DUR Board and agendas are posted on the Family and Social Services Administration (FSSA) Web site at http://www.state.in.us/fssa/ under the heading **Calendar**. Information about the Therapeutics Committee and the PDL can be accessed at http://www.indianapbm.com.

The Therapeutics Committee recommends drugs for the PDL after extensive clinical review. The IHCP anticipates that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented and further developed, as well as recognize and appreciate the clinical and cost effectiveness that it will bring to the IHCP. It is important to note that the cost savings to be realized from the PDL program will enable the OMPP to fund other critically needed services under the IHCP at a time when every possible means of conserving program costs is being explored.

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Important Note: *Prior authorizations approved under the current IRDP clinical programs will be grandfathered to bypass PDL edits until those authorizations expire.* **Please note that other existing authorizations such as Early Refill, High Dose, 34-day Supply, and so forth will *not* be grandfathered and ProDUR edits will still apply when appropriate.**

Table 1 – POS Edit Codes

3017	PDL/Non-PDL Brand Med Necessary associated With PDL / Non-PDL	ACS	1-866-879-0106
3002	IRDP – Indiana Rational Drug Program	HCE	(317) 347-4511 1-800-457-4518
4026	NDC / Days Supply Limits	HCE	(317) 347-4511 1-800-457-4518
0570	Refill Too Soon	HCE	(317) 347-4511 1-800-457-4518
6806	IRDP Therapy Exceeds Limitations	HCE	(317) 347-4511 1-800-457-4518
0573	Drug-Drug Interaction Severity Level 1	HCE	(317) 347-4511 1-800-457-4518
0571	High Dose	HCE	(317) 347-4511 1-800-457-4518
70	Medical Supply Billed POS to ACS	EDS	1-800-577-1278
41	Third Party Liability	EDS	1-800-577-1278

Phase 8 PDL Additions

Important: *In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and "cross indicated" drugs are considered as being on the PDL.*

Important: *The brand products on the non-preferred drug list with generic equivalents are considered non-preferred on the PDL. The generic equivalents do not require prior authorization for non-PDL edits, unless noted otherwise.*

The following drugs are effective May 14, 2003:

Table 2 – Bile Acid Sequestrants

cholestyramine (multi-dose powder containers), **Locholest®** powder and **Prevalite®** powder	**Questran®** all formulations, cholestyramine packets, **Prevalite®** packets
Colestid® (flavored granules multidose container)	**Colestid®** tablets, granule packets
	Welchol®

Table 3 – Fibric Acids

gemfibrozil (all formulations)	**Lopid®**
TriCor® 160mg, 200mg tablets Patients currently taking other doses of TriCor® are grandfathered.	**TriCor®** 54mg and **TriCor®** 67mg
Lofibra® 200mg tablets	

Table 4 – Skeletal Muscle Relaxants

methocarbamol	**Robaxin®**
cyclobenzaprine HCL	**Flexeril®**
baclofen	**Lioresal®**
chlorzoxazone	**Paraflex®, Parafon Forte®**
orphenadrine citrate	**Norflex®, Norgesic Forte®**
tizanidine HCL	**Zanaflex®**
dantrolene sodium	**Dantrium®**
	Skelaxin®
	Soma® (all formulations including combination products)
	carisoprodol (all formulations including combination products)

Table 5 – Urinary Tract Antispasmodic

oxybutynin (Step edit for the long acting formulations. Patients must have been unresponsive to the immediate release formulation to be eligible for a long acting medication.)	**Ditropan®**
	Ditropan® XL Patients currently taking this medication are grandfathered.
	Detrol®
	Detrol® LA Patients currently taking this medication are grandfathered.
	Urispas®

Table 6 – Brand Name Narcotics

All generic narcotic products are considered PDL	
acetaminophen*/codeine #2, #3, #4	**Tylenol® #2, #3, #4**
aspirin with codeine	**Empirin®**
oxycodone* (all combinations)	**Percocet®, Percodan®**
hydromorphone	**Dilaudid®**
pentazocine lactate (all formulations)	**Talwin®** (all formulations)
tramadol HCL The limit for any tramadol formulation is 400 milligrams/day	**Ultram®**
hydrocodone* (all formulations) The limit for any hydrocodone formulation is 1500mg/30 days	**Lorcet® Maxidone® Norco® Zydone® Vicoprofen® Lortab®, Vicodin®**
propoxyphene* (all formulations)	**Darvon® Darvocet N® Darvon® Compound Wygesic®**
Duragesic® Limit: 10 patches/30 day period	**Kadian®**
OxyContin® Limit: 120 tabs/25 days except 80mg tab 60 tabs/25 days.	**Actiq®**
butorphanol nasal spray Limit: 1 vial/25 days (2 vials/25 days with prior authorization).	**Stadol® NS**

Table 7 – Antidiabetic Agents

Glyset®	tolazamide, **Tolinase®**
Precose®	tolbutamide, **Orinase®**
Prandin®	chlorpropamide, **Diabinese®**
Starlix®	acetohexamide, **Dymelor®**
glyburide	**Micronase®, Diabeta®**
metformin	**Glucophage®, Glucophage® XR**
glipizide, **Glucotrol® XL**	**Glucotrol®**
Amaryl®	
Glucovance® Requires previous use of one of the agents in the combination. Patients currently taking these medications are grandfathered and will be reviewed in six months.	

Table 7 – Antidiabetic Agents

Metagip® Requires previous use of one of the agents in the combination. Patients currently taking these medications are grandfathered and will be reviewed in six months.	
Avandamet® Requires previous use of one of the agents in the combination. Patients currently taking these medications are grandfathered and will be reviewed in six months.	

Prior authorization is required for all non-preferred drugs and/or requests for quantities of drugs that exceed the State limit.

Additional Information

Please direct all questions about the PDL and prior authorization needed for non-PDL drugs to the ACS-State Health Care Clinical Call Center at 1-866-879-0106. Please direct any questions about IRDP or ProDUR prior authorizations to the Health Care Excel (HCE) Prior Authorization Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518. Please direct questions about this bulletin to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

PROVIDER BULLETIN

BT200333 JUNE 2, 2003

To: **All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications**

Subject: **Preferred Drug List—New Additions (Phase 9)**

Note: The information in this bulletin does not apply to practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Overview

As stated in the Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200247*, dated September 9, 2002, a Preferred Drug List (PDL) is being implemented for the fee-for-service benefits within the IHCP. The PDL was implemented in April 2003. A complete list of current preferred drugs is being compiled and will be made available on the Web at www.indianapbm.com. The Drug Utilization Review (DUR) Board, at the March 28, 2003, meeting, approved PDL recommendations from the Therapeutics Committee for the following drug classes:

- Ophthalmic Mast Cell Stabilizer, Eye Antihistamines
- Miotics/Other Intraocular Pressure Reducers
- Ophthalmic Antibiotics
- Otic Antibiotics
- Vitamin A Derivatives
- Antisporiatics
- Leukocyte (WBC) Stimulants
- Hematinics
- Ultracet
- Forteo
- Smoking Deterrent Agents

Notice of meetings of the DUR Board and agendas are posted on the Family and Social Services Administration (FSSA) Web site at http://www.state.in.us/fssa/ under the heading **Calendar**. Information about the Therapeutics Committee and the PDL can be accessed at http://www.indianapbm.com.

The Therapeutics Committee recommends drugs for the PDL after extensive clinical review. The IHCP anticipates that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented and further developed, as well as recognize and appreciate the clinical and cost effectiveness that it will bring to the IHCP. It is important to note that the cost savings to be realized from the PDL program will enable the OMPP to fund other critically needed services under the IHCP at a time when every possible means of conserving program costs is being explored.

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Important Note: *Prior authorizations approved under the current Indiana Rational Drug Program (IRDP) clinical programs will be grandfathered to bypass PDL edits until those authorizations expire. Other existing authorizations such as Early Refill, High Dose, 34-day Supply, and so forth* will not *be grandfathered and ProDUR edits will still apply when appropriate.*

Table 1 – POS Edit Codes

Codes	Description	Contact Name	Contact Number
3017	PDL/Non-PDL Brand med necessary associated with PDL/Non-PDL	ACS	1-866-879-0106
3002	IRDP – Indiana Rational Drug Program	HCE	(317) 347-4511 1-800-457-4518
4026	NDC/Days Supply Limits	HCE	(317) 347-4511 1-800-457-4518
0570	Refill Too Soon	HCE	(317) 347-4511 1-800-457-4518
6806	IRDP – Therapy exceeds limitations	HCE	(317) 347-4511 1-800-457-4518
0573	Drug/drug interaction Severity Level 1	HCE	(317) 347-4511 1-800-457-4518
0571	High dose	HCE	(317) 347-4511 1-800-457-4518
70	Medical supply billed POS to ACS	EDS	1-800-577-1278
41	Third party liability	EDS	1-800-577-1278

Phase 9 PDL Additions

Important: *In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and "cross indicated" drugs are considered as being on the PDL.*

Important: *The brand products on the non-preferred drug list with generic equivalents are considered non-preferred on the PDL. The generic equivalents do not require prior authorization for non-PDL edits, unless noted otherwise.*

The following drugs are effective July 21, 2003:

Table 2 – Ophthalmic Mast Cell Stabilizers

Preferred Drug List	Non-Preferred Drug List
Alamast®	Alocril®
Livostin®	Alomide®
cromolyn	Crolom®
Step edit for the following: Patanol®, Optivar®, Zaditor®. Patients must have been unresponsive to one of the PDL medications listed above; used during the last 12 months. (no grandfathering)	Emadine®
	Opticrom®

Table 3 – Miotics/Other Intraocular Pressure Reducers

Preferred Drug List		Non-Preferred Drug List	
betaxol	**Xalatan®**	Betoptic-S®	Humorsol®
levobunolol	**Travatan®**	Betagan®	Isopto-Eserine®
timolol	**Lumigan®**	Timoptic®	Phospholine Iodide
carteolol	**Iopidine®**	Timoptic® XE	Pilocar®
metipranolol	**Trusopt®**	Betimol®	Isopto-Carpine®
epinephrine	**Azopt®**	Ocupress®	Pilopine-HS®
physostigmine	Isopto-Carbachol®	Opti-Pranolol®	E-Pilo-X®
pilocarpine	Cosopt®	Rescula®	

Table 4 – Otic Antibiotics

Preferred Drug List	Non-Preferred Drug List
All generic products	Chloromycetin®
chloramphenicol	Coly-Mycin® S
neomycin, polymyxin B & hydrocortisone	Cortisoprin®
polymyxin B & hydrocortisone	Octicair®
Floxin®	Otobiotic®
	Otosporin®
	Pediotic®

Table 5 – Ophthalmic Antibiotics

Preferred Drug List		Non-Preferred Drug List	
All generic products	neomycin, polymyxin B & dexamethasone	Any brand name available generically	Neo-Decadron®
bacitracin	**polymyxin B & bacitracin**	AK-Tracin®	Neosporin®
chloramphenicol	**polymyxin B & trimethoprim**	Chloroptic®	Poly-Pred®
erythromycin	**terramycin & polymyxin B**	Ciloxin®	Polysporin®
gentamicin	**tobramycin**	Cortisporin®	Polytrim®
gentamicin & prednisolone	**Ocuflox®**	Ilotycin®	Pred-G®
natamycin		Garamycin®	Tobrex®
neomycin, polymyxin B & bacitracin		Maxitrol®	Tobradex®
neomycin, polymyxin B & gramicidin		Natacyn®	Quixin®
neomycin, polymyxin B & prednisolone		Neo-Dexameth®	

Table 6 – Vitamin A Derivatives

Preferred Drug List **Note: The medications in this class will be approved for patients < or = 25 years of age**	Non-Preferred Drug List
All generic tretinoin products	Retin-A® (brand name products)
Accutane® (brand and generic)	Avita®
Differin® **Step edit (requires step edit of one year previous use of tretinoin product)**	

Table 7 – Antipsoriatics

Preferred Drug List	Non-Preferred Drug List
Dovonex®	Not Applicable
Drithocreme® HP	
Oxsoralen-Ultra®	
Psoriatic®	
Soriatane®	
Tazorac®	

Table 8 – Leukocyte (WBC) Stimulants

Preferred Drug List	Non-Preferred Drug List
Neupogen® (vials only)	Neupogen® (prefilled syringes)
Leukine® (vials only)	Neulasta® (vials and syringes)

Table 9 – Hematinics

Preferred Drug List	Non-Preferred Drug List
Aranesp®	**Not Applicable**
Epogen®	
Procrit®	

Table 10 – Ultracet®

Preferred Drug List **Limited to 400mg tramadol per day or 3 grams acetaminophen per day**	Non-Preferred Drug List
tramadol /acetominophen	**Ultracet®**

Table 11 – Forteo®

Preferred Drug List	Non-Preferred Drug List
Not Applicable	**Forteo® (Forteo PA Criteria)**

Table 12 – Smoking Deterrent Agents

Preferred Drug List Limited to 12 weeks of therapy every 365 days per statute	Non-Preferred Drug List
nicotine patch	**Nicoderm®**
Nicotrol® NS	**Habitrol®**
Nicotrol® Inhaler	**Nicotrol®**
nicotine gum	**Nicorette®**
Commit® lozenge	**Nicorette® DS**

Prior authorization is required for all non-preferred drugs and/or requests for quantities of drugs that exceed the State limit.

Additional Information

Direct questions about the PDL and prior authorization needed for non-PDL drugs to the ACS-State Health Care Clinical Call Center at 1-866-879-0106. Direct questions about the IRDP or ProDUR prior authorizations to the Health Care Excel (HCE) Prior Authorization Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518. Direct questions about this bulletin to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200337 JUNE 6, 2003

To: All Pharmacy Providers and Prescribing Practitioners

Subject: Implementation of Prior Authorization for Therapeutic Duplication ProDUR Alerts

Note: The information referenced below is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

Overview

This bulletin announces the implementation of prior authorization (PA) for Therapeutic Duplication Prospective Drug Utilization Review (ProDUR) alerts effective July 21, 2003. The description of the Therapeutic Duplication ProDUR alert published in Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200221*, dated May 15, 2002, states, "Therapeutic duplication is defined as the use or prescribing of two or more drug products of the same therapeutic class, based on criteria published by First DataBank." The Therapeutic Duplication prior authorization implementation will occur gradually by therapeutic class as defined by First DataBank.

The first two therapeutic classes being implemented are Angiotensin Converting Enzyme Inhibitors (ACES) and Angiotensin Receptor Blockers (ARBS). When further classes requiring PA are implemented provider notification will be sent before the implementation date.

Prior Authorization Process

Claims submitted to Affiliated Computer Services, Inc. (ACS) for the ACES and ARBS that post the Therapeutic Duplication alert explanation of benefits (EOB) codes *0572-Therapeutic Dup ProDUR Alert* and *3002-Prior Authorization Required From HCE* will deny at point of service (POS). Pharmacists will not be permitted to override the alert.

- Pharmacists can obtain PA from Health Care Excel (HCE) when one of the drugs has actually been discontinued.
- Prescribers must obtain PA from HCE when multiple products of the same therapeutic class are being dispensed. Supporting clinical rationale for the Therapeutic Duplication is required to support the PA. The PA form for Therapeutic Duplication is available on the IHCP Web site at: http://www.indianamedicaid.com/ihcp/Forms/RDP_Auth.pdf

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Emergency Situations

In instances when PA cannot be immediately obtained, *42 U.S.C. § 1396r-8* provides for dispensing of a 72-hour supply of a covered prescription drug in an emergency situation. Pharmacists who dispense a 72-hour supply of a covered prescription drug will be reimbursed by the IHCP if, subsequent to dispensing in an emergency, indication is made on the claim that the supply was a necessary emergency.

Additional Information

Refer questions about this policy to the HCE Pharmacy Benefit Management Call Center at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200342 JUNE 23, 2003

To: All Pharmacy Providers and Prescribing Practitioners

Subject: Preferred Drug List—New Additions (Phase 10)

Note: The information in this bulletin does not apply to practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Overview

As stated in the Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200247*, dated September 9, 2002, a Preferred Drug List (PDL) is being implemented for the fee-for-service benefits within the IHCP. A complete list of current preferred drugs is being compiled and will be made available on the Web at www.indianapbm.com. The Drug Utilization Review (DUR) Board, at the April 25, 2003 and the May 23, 2003, meetings, approved PDL recommendations from the Therapeutics Committee for the following drug classes and drugs:

- Antiviral (Influenza) Agents
- Antiviral (Antiherpetic) Agents
- Topical Antifungals
- Oral Antifungals
- Vaginal Antimicrobials
- Topical Estrogen Agents
- Anti-Ulcer/H. Pylori Agents
- Cipro HC®
- Alphagan P®

Notice of meetings of the DUR Board and agendas are posted on the Indiana Family and Social Services Administration (IFSSA) Web site at http://www.state.in.us/fssa/ under the heading **Calendar**. Information about the Therapeutics Committee and the PDL can be accessed at http://www.indianapbm.com.

The Therapeutics Committee recommends drugs for the PDL after extensive clinical review. The IHCP anticipates that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented and further developed, as well as recognize and appreciate the clinical and cost effectiveness that it will bring to the IHCP. It is important to note that the cost savings to be realized from the PDL program will enable the OMPP to fund other critically needed services under the IHCP at a time when every possible means of conserving program costs is being explored.

Important Note: Other existing authorizations such as Early Refill, High Dose, 34-day Supply, and so forth will not be grandfathered and ProDUR edits will still apply when appropriate.

Phase 10 PDL Additions

***Important**: In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and "cross indicated" drugs are considered as being on the PDL.*

Table 1 – POS Edit Codes

Codes	Description	Contact Name	Contact Number
3017	PDL/Non-PDL Brand Med Necessary associated With PDL / Non-PDL	ACS	1-866-879-0106
3002	IRDP – Indiana Rational Drug Program	HCE	(317) 347-4511 1-800-457-4518
4026	NDC / Days Supply Limits	HCE	(317) 347-4511 1-800-457-4518
0570	Refill Too Soon	HCE	(317) 347-4511 1-800-457-4518
6806	IRDP Therapy Exceeds Limitations	HCE	(317) 347-4511 1-800-457-4518
0573	Drug-Drug Interaction Severity Level 1	HCE	(317) 347-4511 1-800-457-4518
0571	High Dose	HCE	(317) 347-4511 1-800-457-4518
70	Medical Supply Billed POS to ACS	EDS	1-800-577-1278
41	Third Party Liability	EDS	1-800-577-1278

***Important**: The brand products on the non-preferred drug list with generic equivalents are considered non-preferred on the PDL. The generic equivalents do not require prior authorization for non-PDL edits, unless noted otherwise.*

The following drugs are effective August 6, 2003

Table 2 – Antiviral (Influenza) Agents

Preferred Drug List	Non-Preferred Drug List
Amantidine (generic products)	Relenza®
Rimantidine (generic products)	Tamiflu®
	Symmetrel®
	Flumadine®

Table 3 – Antiviral (Antiherpetic) Agents

Preferred Drug List	Non-Preferred Drug List
Acyclovir (generic products)	Famvir®
Valtrex®	Zovirax® 600mg tablets
Zovirax® 200mg capsules	Zovirax® 800mg tablets
Zovirax® 400mg tablets	
Zovirax® Suspension	

Table 4 – Topical Antifungals

Preferred Drug List	Non-Preferred Drug List	
All generic products	Exelderm®	Nilstat®
Clotrimazole	Lamisil AT®	Nizoral®
Miconazole	Loprox®	Oxistat®
Econazole	Lotrimin®	Penlac®
	Mentax®	Spectazole®
	Micatin®	Tinactin®
	Naftin®	

Table 5 – Oral Antifungals*

Preferred Drug List	Non-Preferred Drug List
Diflucan® all doses and all formulations; (Diflucan® 150mg is limited to 2 tablets every 14 days) (Phase 6)	Nizoral® (Phase 6)
Ketoconazole (generic products) (Phase 6)	Sporanox® (Phase 6)
Grifulvin® V (Phase 10)	Lamisil® (Phase 6)
Griseofulvin tablets (generic products) (Phase 10)	Vfend® (Phase 6)
	Fulvicin® (Phase 10)
	Grisactin® (Phase 10)
	Gris-PEG® (Phase 10)

*The DUR Board moved to add Grifulvin®, and griseofulvin to the PDL and Fulvicin®, Grisactin®, and Gris-PEG® to Non-PDL under the oral antifungals previously reviewed as Phase 6 for the Preferred Drug List.

Table 6 – Vaginal Antimicrobials

Preferred Drug List	Non-Preferred Drug List	
All generic products	Cleocin® Vaginal cream/ovules	Metrogel® Vaginal
Clotrimazole	Terazol®	Mycelex®
Miconazole	Gynazole® 1	Monistat®
Tioconazole	Gyne-Lotrimin®	Vagistst-1®

Table 7 – Topical Estrogen Agents

Preferred Drug List	Non-Preferred Drug List
Estrace Vaginal Cream®	Not applicable
Vagifem®	
Estring®	
Premarin®Vaginal Cream	
Ortho-Dienestrol®	
Ogen®	

Table 8 – Antiulcer / H. Pylori Agents

Preferred Drug List	Non-Preferred Drug List
Not Applicable	PrevPac®
	Helidac®

Due to the loss of quorum at the April 25, 2003, DUR Board, Cipro HC® and Alphagan P® were reviewed at the May 23, 2003, meeting and assigned the following status on the PDL.

Table 9 – Otic Antibiotics (Addition from Phase 9)

Preferred Drug List	Non-Preferred Drug List
Cipro HC® (preferred for patients 12 and under)	**Cipro HC® (patients age 13 and over)**
See provider bulletin *BT200333* Phase 9 for other PDL agents	

Table 10 – Miotics/Other Intraocular Pressure Reducers (Addition from Phase 9)

Preferred Drug List	Non-Preferred Drug List
See provider bulletin *BT200333* Phase 9 for other PDL agents	**Alphagan P® (grandfathered for one year for patients receiving therapy prior to phase 10 of the PDL)**

Prior authorization is required for all non-preferred drugs and/or requests for quantities of drugs that exceed the State limit.

Additional Information

Direct questions about the PDL and prior authorization needed for non-PDL drugs to the ACS-State Health Care Clinical Call Center at 1-866-879-0106. Direct any questions about the Indiana Rational Drug Program (IRDP) or ProDUR prior authorizations to the Health Care Excel (HCE) Prior Authorization Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518. Direct questions about this bulletin to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200350 JULY 22, 2003

To: All Pharmacy and Prescribing Practitioners

Subject: Implementation of Prior Authorization for Therapeutic Duplication ProDUR Alerts

Note: The information referenced below is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

Overview

This bulletin announces the continuation of the implementation of prior authorization (PA) for Therapeutic Duplication Prospective Drug Utilization Review (ProDUR) alerts effective September 9, 2003. The following is the description of the therapeutic duplication ProDUR alert as published in provider bulletin *BT200221*, dated May 15, 2002: "Therapeutic duplication is defined as the use or prescribing of two or more drug products of the same therapeutic class, based on criteria published by First DataBank." Therapeutic duplication PA will be implemented gradually by therapeutic class as defined by First DataBank.

The first two therapeutic classes implemented July 21, 2003, requiring PA for therapeutic duplication were Angiotensin Converting Enzyme Inhibitors (ACES) and Angiotensin Receptor Blockers (ARBS) as published in provider bulletin *BT200337*, dated June 6, 2003. In addition to the ACES and the ARBS, the classes in Table 1 will require PA for therapeutic duplication as of September 9, 2003.

Prior Authorization Process

Claims submitted to ACS posting the therapeutic duplication alert explanation of benefits (EOB) codes *0572 – Therapeutic Duplication* and *3002 – Prior Authorization Required From HCE* will deny at the point-of-sale (POS). Pharmacists will not be permitted to override the alert at POS.

- Pharmacists can obtain PA from Health Care Excel (HCE) when one of the drugs has been discontinued.
- Prescribers must obtain PA from HCE when multiple products of the same therapeutic class are being dispensed. Supporting clinical rationale for the therapeutic duplication is required to support the PA. The prior authorization form for therapeutic duplication can be found at: http://www.indianamedicaid.com/ihcp/Forms/RDP_Auth.pdf

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Table 1 – Listing of Therapeutic Classes

Therapeutic Classes Requiring Prior Authorization for Therapeutic Duplication	
Calcium Channel Blocking Agents	Streptogramins
Anti-Hyperlipidemics	Aminocyclitols
Osmotic Diuretics	Vancomycin and Derivatives
Inorganic Salt Diuretics	Lincosamides
Mercurial Diuretics	Polymyxin and Derivatives
Carbonic Anhydrase Inhibitors	Oxazolidinones
Thiazide and Related Diuretics	Betalactams
Potassium Sparing Diuretics	Quinolones
Aminouracil Diuretics	Beta-Lactamase Inhibitors
Potassium Sparing Diuretics in Combination	Carbapenems (Thienamycins)
Loop Diuretics	Cephalosporins – 1st Generation
Penicillins	Cephalosporins – 2nd Generation
Tetracyclines	Cephalosporins – 3rd Generation
Macrolides	Cephalosporins – 4th Generation
Chloramphenicol and Derivatives	Absorbable Sulfonamides
Aminoglycosides	Non-Absorbable Sulfonamides
Antitubercular Antibiotics	

Emergency Situations

When PA cannot be immediately obtained, *42 U.S.C. § 1396r-8* provides for dispensing of a 72-hour supply of a covered prescription drug in an emergency situation. Pharmacists who dispense a 72-hour supply of a covered prescription drug will be reimbursed by the Indiana Health Coverage Programs (IHCP) if, subsequent to dispensing in an emergency, indication is made on the claim that the supply was a necessary emergency.

Additional Information

Refer questions about this policy to the HCE Pharmacy Benefit Management Call Center at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200351 JULY 28, 2003

To: All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications

Subject: Preferred Drug List – Re-review of Proton Pump Inhibitors and Thiazolidinediones

Note: The information in this bulletin does not apply to practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Overview

This bulletin announces that at the June 20, 2003, Drug Utilization Review (DUR) Board meeting, the board approved the re-reviewed Preferred Drug List (PDL) recommendations from the Therapeutics Committee for the following drug classes:

- Proton Pump Inhibitors
- Thiazolidinediones

As stated in the Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200247*, dated September 9, 2002, a PDL was developed and implemented for the fee-for-service benefits within the IHCP. A complete list of current preferred drugs is available on the Web at www.indianapbm.com.

The DUR Board also approved the Therapeutics Committee recommendation to limit the H2 Receptor Blockers to 60 tablets every 30 days.

Notice of the DUR Board meetings and agendas are posted on the Family and Social Services Administration (FSSA) Web site at http://www.state.in.us/fssa/ under the heading **Calendar**. Information about the Therapeutics Committee and the PDL can be accessed at http://www.indianapbm.com.

The Therapeutics Committee recommends drugs for the PDL after extensive clinical review. The IHCP anticipates that prescribers and pharmacists will support and encourage the use of the PDL, as well as recognize and appreciate the clinical and cost effectiveness that it will bring to the IHCP. It is important to note that the cost savings to be realized from the PDL program will enable the Office of Medicaid Policy and Planning (OMPP) to fund other critically needed services under the IHCP at a time when every possible means of conserving program costs is being explored.

Important Note: Other existing authorizations such as Early Refill, High Dose, 34-day Supply, and so forth will not be grandfathered and ProDUR edits will still apply when appropriate.

Table 1 – POS Edit Codes

Codes	Description	Contact Name	Contact Number
3017	PDL/Non-PDL Brand Med Necessary associated With PDL / Non-PDL	ACS	1-866-879-0106
3002	IRDP – Indiana Rational Drug Program	HCE	(317) 347-4511 1-800-457-4518
4026	NDC / Days Supply Limits	HCE	(317) 347-4511 1-800-457-4518
0570	Refill Too Soon	HCE	(317) 347-4511 1-800-457-4518
6806	IRDP Therapy Exceeds Limitations	HCE	(317) 347-4511 1-800-457-4518
0573	Drug-Drug Interaction Severity Level 1	HCE	(317) 347-4511 1-800-457-4518
0571	High Dose	HCE	(317) 347-4511 1-800-457-4518
70	Medical Supply Billed POS to ACS	EDS	1-800-577-1278
41	Third Party Liability	EDS	1-800-577-1278

PDL Re-Review

Important: *In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and "cross indicated" drugs are considered as being on the PDL.*

Important: *The brand products on the non-preferred drug list with generic equivalents are considered non-preferred on the PDL. The generic equivalents do not require prior authorization for non-PDL edits, unless noted otherwise.*

Table 2 lists drugs on the PDL effective September 12, 2003:

Table 2 – Proton Pump Inhibitors

Preferred Drug List* This class is limited to 30 units every 30 days.	Non-Preferred Drug List
Protonix®	Aciphex®
Omeprazole (generic products)	Nexium®
	Prevacid®
	Prevacid Solutab®
	Prilosec®

***This class must go through the H2 Receptor Blocker step edit process. Patients must fail an H2 Receptor Blocker within the previous six months. All patients with a proton pump inhibitor prior authorization are not subject to the step edit.**

Table 3 – Thiazolidinediones

Preferred Drug List* This class is limited to 30 units every 30 days.	Non-Preferred Drug List
Actos® 15, 30 and 45 mg	Avandia® 2mg
Avandia® 4 and 8 mg	

***This class must go through the metformin step edit process. Patients must fail metformin within the previous six weeks. All patients currently taking a thiazolidinedione are not subject to the step edit.**

Prior authorization is required for all non-preferred drugs and/or requests for quantities of drugs that exceed the State limit.

Additional Information

Direct questions about the PDL and prior authorization needed for non-PDL drugs to the ACS-State Health Care Clinical Call Center at 1-866-879-0106. Direct any questions about the Indiana Rational Drug Program (IRDP) or ProDUR prior authorizations to the Health Care Excel (HCE) Prior Authorization Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518. Direct questions about this bulletin to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

PROVIDER BULLETIN

BT200359 SEPTEMBER 5, 2003

To: **All Pharmacy Providers and Prescribing Practitioners**

Subject: **Preferred Drug List—Re-review**

Overview

This bulletin announces that at the August 15, 2003, Drug Utilization Review (DUR) Board meeting, the board approved the re-reviewed Preferred Drug List (PDL) recommendations from the August 1, 2003, Therapeutics Committee meeting. The complete PDL lists can be found in the tables contained in this bulletin.

As stated in the Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200247*, dated September 9, 2002, a PDL was developed and implemented for the fee-for-service benefits within IHCP. A complete list of current preferred drugs is available on the Internet at www.indianapbm.com. The next re-review of the PDL will occur at the November 7, 2003, Therapeutics Committee meeting.

Notice of the DUR Board meetings and agendas are posted on the Family and Social Services Administration (FSSA) Web site at http://www.state.in.us/fssa/ under the heading **Calendar**. Information about the Therapeutics Committee and the PDL can be accessed at http://www.indianapbm.com.

The Therapeutics Committee recommends drugs for the PDL after extensive clinical review. The IHCP anticipates that prescribers and pharmacists will support and encourage the use of the PDL, as well as recognize and appreciate the clinical and cost effectiveness that it will bring to the IHCP. It is important to note that the cost savings to be realized from the PDL program will enable the Office of Medicaid Policy and Planning (OMPP) to fund other critically needed services under the IHCP at a time when every possible means of conserving program costs is being explored.

Note: Other existing authorizations such as Early Refill, High Dose, 34-day Supply, and so forth, will not be grandfathered and Prospective DUR (ProDUR) edits will still apply when appropriate.

Table 1 – POS Edit Codes

3017	PDL/Non-PDL Brand med necessary associated with PDL/Non-PDL	ACS	1-866-879-0106
3002	Indiana Rational Drug Program (IRDP)	HCE	(317) 347-4511 1-800-457-4518
4026	National Drug Code (NDC)/Days Supply Limits	HCE	(317) 347-4511 1-800-457-4518
0570	Refill too soon	HCE	(317) 347-4511 1-800-457-4518
6806	IRDP Therapy exceeds limitations	HCE	(317) 347-4511 1-800-457-4518
0573	Drug/Drug interaction severity Level 1	HCE	(317) 347-4511 1-800-457-4518
0571	High dose	HCE	(317) 347-4511 1-800-457-4518
70	Medical supply billed point of sale (POS) to ACS	EDS	1-800-577-1278
41	Third Party Liability	EDS	1-800-577-1278

Preferred Drug List

Important: *In accordance with Indiana law, all anticonvulsant, antidepressant, antipsychotic, and* cross indicated *drugs are considered to be on the PDL.*

Important: *The brand products on the non-preferred drug list with generic equivalents are considered non-preferred on the PDL. The generic equivalents do not require prior authorization for non-PDL edits, unless noted otherwise.*

The following tables contain the Preferred Drug List effective October 20, 2003:

Table 2 – IHCP Preferred Drug List, Cardiovascular

Preferred Drugs	
captopril 12.5mg tabs	12 years and younger
captopril 25mg tabs	12 years and younger
captopril 50mg tabs	12 years and younger
captopril 100mg tabs	12 years and younger
enalapril	All strengths
lisinopril	All strengths
Lotensin 10mg tabs	

Table 2 – IHCP Preferred Drug List, Cardiovascular

Lotensin 20mg tabs	
Lotensin 40mg tabs	
Mavik 1mg tabs	
Mavik 2mg tabs	
Mavik 4mg tabs	
Monopril 10mg tabs	
Monopril 20mg tabs	
Monopril 40mg tabs	
moexepril	All strengths
Non Preferred Drugs	
Accupril 5mg tabs	
Accupril 10mg tabs	
Accupril 20mg tabs	
Accupril 40mg tabs	
Aceon 2mg tabs	
Aceon 4mg tabs	
Aceon 8mg tabs	
Altace 1.25mg caps	
Altace 2.5mg caps	
Altace 5mg caps	
Altace 10mg caps	
Capozide*	
captopril 12.5mg tabs	Older than 12 years old
captopril 25mg tabs	Older than 12 years old
captopril 50mg tabs	Older than 12 years old
captopril 100mg tabs	Older than 12 years old
Prinivil*	
Univasc 7.5mg tabs*	
Univasc 15mg tabs*	
Vasotec*	
Zestril*	

(Continued)

Table 2 – IHCP Preferred Drug List, Cardiovascular

Preferred Drugs	
Lotrel	30 tabs per month
Tarka	
Non-Preferred Drugs	
Lexxel	
Preferred Drugs	
captopril/HCTZ	
enalapril/HCTZ	
lisinopril/HCTZ	
Lotensin HCT	
Monopril HCT	
Non-Preferred Drugs	
Accuretic	
Capozide*	
Prinzide*	
Vaseretic*	
Uniretic	
Zestoretic*	
Preferred Drugs	
doxazosin	All strengths
prazosin	All strengths
terazosin	All strengths
Non-Preferred Drugs	
Cardura tabs*	All strengths
Hytrin caps*	All strengths
Minipress caps*	All strengths
Preferred Drugs	
Cozaar (subject to step edit for ACEI)	1 tablet per day
Micardis (subject to step edit for ACEI)	1 tablet per day

(Continued)

Table 2 – IHCP Preferred Drug List, Cardiovascular

Benicar (subject to step edit for ACEI)	
Non-Preferred Drugs	
Atacand	
Avapro	
Diovan	
Teveten	
Preferred Drugs	
Hyzaar	
Micardis HCT	
Benicar HCT	
Non-Preferred Drugs	
Atacand HCT	
Avalide	
Diovan HCT	
Preferred Drugs	
Coreg	Step edit, must be on a diuretic and Coreg limited to 90 tablets per dosage strength per 30 days
labetalol	All strengths and formulations
Non-Preferred Drugs	
Normodyne 100mg tabs*	
Normodyne 200mg tabs*	
Normodyne 300mg tabs*	
Trandate 100mg tabs*	
Trandate 200mg tabs*	
Trandate 300mg tabs*	
Preferred Drugs	
acebutolol	All strengths
atenolol	All strengths
betaxolol 10mg tabs	
betaxolol 20mg tabs	

(Continued)

Table 2 – IHCP Preferred Drug List, Cardiovascular

bisoprolol	All strengths
Inderal 10mg tabs**	
Inderal 20mg tabs**	
Inderal 40mg tabs**	
Inderal 60mg tabs**	
Inderal 80mg tabs**	
Inderal-LA	All LA strengths
InnoPran XL	
Lopressor 50mg tabs**	
Lopressor 100mg tabs**	
metoprolol	All strengths and formulations
nadolol	All strengths
pindolol	All strengths
propranolol	All strengths and formulations
sotalol 80mg tabs	
sotalol 120mg tabs	
sotalol 160mg tabs	
sotalol 240mg tabs	
Tenormin 25mg tabs**	
Tenormin 50mg tabs**	
Tenormin 100mg tabs**	
Timolol 5mg tabs	
Timolol 10mg tabs	
Timolol 20mg tabs	
Toprol XL 25mg tabs	
Toprol XL 50mg tabs	
Toprol XL 100mg tabs	
Toprol XL 200mg tabs	
Non-Preferred Drugs	
Betapace 80mg tabs*	
Betapace 120mg tabs*	
Betapace 160mg tabs*	
Betapace 240mg tabs*	

(Continued)

Table 2 – IHCP Preferred Drug List, Cardiovascular

Betapace AF 80mg tabs	
Betapace AF 120mg tabs	
Betapace AF 160mg tabs	
Blocadren 5mg tabs*	
Blocadren 10mg tabs*	
Blocadren 20mg tabs*	
Cartrol 2.5mg tabs	
Cartrol 5mg tabs	
Corgard 20mg tabs*	
Corgard 40mg tabs*	
Corgard 80mg tabs*	
Corgard 120mg tabs*	
Corgard 160mg tabs*	
Kerlone 10mg tabs	
Kerlone 20mg tabs	
Levatol 20mg tabs	
Sectral 200mg caps*	
Sectral 400mg caps*	
Visken 10mg tabs*	
Visken 5mg tabs*	
Zebeta 5mg tabs*	
Zebeta 10mg tabs*	
Preferred Drugs	
Adalat CC 90mg tabs	
Calan**	All strengths
Covera-HS 180mg tabs	
Covera-HS 240mg tabs	
diltiazem	All forms/strengths
Dynacirc	All strengths
Dynacirc CR 5mg tabs	
Dynacirc CR 10mg tabs	
Isoptin**	All strengths

(Continued)

Table 2 – IHCP Preferred Drug List, Cardiovascular

nicardipine	All strengths
nifedipine long-acting	All strengths
Nimotop 30mg caps	
Norvasc	All strengths
Plendil	All strengths
Sular	All strengths
Tiazac	All strengths
verapamil	All strengths
Verelan PM 100mg caps	
Verelan PM 200mg caps	
Verelan PM 300mg caps	
Verelan 120mg caps**	
Verelan 180mg caps**	
Verelan 240mg caps**	
Verelan 360mg caps**	
Non-Preferred Drugs	
Adalat 10mg caps*	
Adalat 20mg caps*	
Adalat CC 30mg tabs*	
Adalat CC 60mg tabs*	
Cardene 20mg caps	
Cardene 30mg caps	
Cardene SR 30mg caps	
Cardene SR 45mg caps	
Cardene SR 60mg caps	
Cardizem*	All strengths
Dilacor XR 120mg caps	
Dilacor XR 180mg caps	
Dilacor XR 240mg caps	
nifedipine(short acting)	All strengths
Procardia 10mg caps*	
Procardia 20mg caps*	
Procardia XL 30mg tabs*	

(Continued)

Table 2 – IHCP Preferred Drug List, Cardiovascular

Procardia XL 60mg tabs*	
Procardia XL 90mg tabs	
Vascor 200mg tabs	
Vascor 300mg tabs	

Table 3 – IHCP Preferred Drug List, Respiratory System

Preferred Drugs	
Accolate	
Singulair	Step edit, must have had one of the following medications, methylxanthine, beta agonist, and/or inhaled corticosteroid within the past six months
Non-Preferred Drugs	
ZyFlo	
Preferred Drugs	
Serevent	
Non-Preferred Drugs	
Foradil	
Preferred Drugs	
albuterol	All formulations and strengths excluding tablets
albuterol inhalers	Limit three canisters per month for ages < 19; two canisters per month for ages 19 and older
Non-Preferred Drugs	
albuterol tablets	Brand and generic, all strengths and formulations
Alupent	
Brethine	
MaxAir	
Prometa	

(Continued)

Table 3 – IHCP Preferred Drug List, Respiratory System

Proventil*	
Proventil HFA	
Tornalate	
Ventolin*	
Xopenex	
Preferred Drugs	
Advair 100/50	
Advair 250/50	
Advair 500/50	Step edit, must have failed Advair 100/50 or 250/50 or Flovent within the past 30 days
Non-Preferred Drugs	
None	
Preferred Drugs	
Azmacort	
Flovent 44mcg Inhaler	
Flovent 110mcg Inhaler	
Pulmicort Respules	Limited to age 6 and younger
Pulmicort Turbohaler	For patients age 6 and older limited to 1 per month
Qvar	
Non-Preferred Drugs	
AeroBID and AeroBID M	
Beclovent	
Flovent 220mcg Inhaler	
Flovent Rotadisk	
Vanceril and Vanceril DS	
Preferred Drugs	
Astelin	
Beconase	
Beconase AQ	
Flonase	
Nasacort	

(Continued)

Table 3 – IHCP Preferred Drug List, Respiratory System

Nasacort AQ	
Nasalide	
Nasarel	
Nasonex	
Rhinocort	
Rhinocort AQ	
Tri-Nasal	
Vancenase	
Vancenase AQ	
Vancenase AQ DS	
Non-Preferred Drugs	
None	
Preferred Drugs	
Allegra 180mg tabs	Step edit, must have failed a two-week trial of over-the-counter (OTC) loratadine within previous three months; limit of one tablet per day
Allegra 30mg tabs	Step edit, must have failed a two-week trial of OTC loratadine within previous three months; limit of two tablets per day
Allegra 60mg tabs/caps	Step edit, must have failed a two-week trial of OTC loratadine within previous three months; limit of two tablets or capsules per day
Zyrtec 1mg/ml syrup	For children six years of age or younger; limit of 10 ml per day
Non-Preferred Drugs	
Allegra-D tabs	
Clarinex 5mg tabs	
Claritin 10mg redi-tabs	
Claritin 10mg tabs	
Claritin 10mg/10ml syrup	
Claritin-D 12 hour tabs	
Claritin-D 24 hour tabs	
Zyrtec 5mg tabs	
Zyrtec 10mg tabs	

(Continued)

Table 3 – IHCP Preferred Drug List, Respiratory System

Zyrtec-D 12 hour tabs	

Table 4 – IHCP Preferred Drug List, Anti-Infectives

*Beginning in January of 2003, all fluoroquinolones will be limited to a 14-day supply unless otherwise noted below.	
Preferred Drugs	
Cipro	
Cipro XR	Limited to three tablets per prescription; no refills
Factive	
Tequin TEQ-PAC one per month	
Levaquin	
Maxaquin	
Avelox ABC PAC one per month	
Noroxin	
Floxin	
Zagam	
Preferred Drugs	
All generic first generation cephalosporins	
Preferred Drugs	
All generic second generation cephalosporins	
Non-Preferred Drugs	
Ceftin Brand*	
Ceclor Brand*	
Cefzil	
Lorabid	

(Continued)

Table 4 – IHCP Preferred Drug List, Anti-Infectives

Preferred Drugs	
Omnicef	
Suprax	
Non-Preferred Drugs	
Cedax	
Spectracef	
Vantin	
Preferred Drugs	
Diflucan 50mg tablets	
Diflucan 100mg tablets	
Diflucan 150mg tablets	150 mg tablets limited to two tablets every 14 days
Diflucan 200mg tablets	
Diflucan suspension	
Grifulvin V	
griseofulvin tablets	
ketoconazole generics	
Non-Preferred Drugs	
Fulvicin	
Grisactin	
Grisactin	
Nizoral Brand*	
Sporanox	
Lamisil	
Vfend	
Preferred Drugs	
All generic products	
clotrimazole	
econazole	
miconazole	

(Continued)

Table 4 – IHCP Preferred Drug List, Anti-Infectives

Non-Preferred Drugs	
Exelderm	
Lamisil AT	
Loprox	
Lotrimin	
Mentax	
Micatin	
Naftin	
Nilstat	
Nizoral	
Oxistat	
Penlac	
Spectazole	
Tinactin	
Preferred Drugs	
Zithromax, Z-PAK, TRI-PAK	1 Z-PAK or 1 TRI-PAK per month
Biaxin, Biaxin XL PAC	Biaxin XL PAC 1 pack per month
Dynabac, D-5PAC	D-5 PAC 1 pack per month
erythromycin*	
Non-Preferred Drugs	
Brand erythromycin products	
Preferred Drugs	
all generic products	
chloramphenicol	
Cipro HC	12 years old and under
neomycin, polymyxin B & hydrocortisone	
polymyxin B & hydrocortisone	
Floxin	
Non-Preferred Drugs	
Chloromycetin	
Cipro HC	13 years old and over

(Continued)

Table 4 – IHCP Preferred Drug List, Anti-Infectives

Coly-Mycin S	
Cortisoprin	
Octicair	
Otobiotic	
Otosporin	
Pediotic	
Preferred Drugs	
acyclovir	All strengths and formulations
Zovirax 200 mg caps	
Zovirax 400 mg tabs	
Non-Preferred Drugs	
Famvir	
Zovirax 600mg tabs	
Zovirax 800mg tabs	
Valtrex	Step edit requires HIV therapy
Zovirax Suspension	
Preferred Drugs	
amantidine	Generic products
rimantidine	Generic products
Non-Preferred Drugs	
Flumadine	
Relenza	
Symmetrel	
Tamiflu	
Preferred Drugs	
all generic products	
bacitracin	
chloramphenicol	
erythromycin	
gentamicin	

(Continued)

Table 4 – IHCP Preferred Drug List, Anti-Infectives

natamycin	
neomycin, polymyxin B & bacitracin	
neomycin, polymyxin B & gramicidin	
polymyxin B & bacitracin	
polymyxin B & trimethoprim	
terramycin & polymyxin B	
tobramycin	
Ciloxan Drops	
Ocuflox	
Non-Preferred Drugs	
Any brand name available generically	
AK-Tracin	
Chloroptic	
Ciloxan Ointment	
Cortisporin	
Ilotycin	
Garamycin	
Natacyn	
Neosporin	
Polysporin	
Polytrim	
Tobrex	
Vigamox	
Zymar	
Preferred Drugs	
all generic products	
gentamicin and prednisolone	
neomycin, polymyxin B and prednisolone	
neomycin, polymyxin B and dexamethasone	
Non-Preferred Drugs	
Any brand name available generically	
Maxitrol	

(Continued)

Table 4 – IHCP Preferred Drug List, Anti-Infectives

Neo-Dexameth	
Neo-Decadron	
Poly-Pred	
Pred-G	
Tobradex	

Table 5 – IHCP Preferred Drug List, Blood Products

Preferred Drugs	
Altocor	
Lescol	
Lescol XL	
Lipitor	
lovastatin	
Pravachol	Step edit requires HIV therapy
Zocor	
Non-Preferred Drugs	
Advicor	
Mevacor*	

Preferred Drugs	
Plavix 75mg tabs	
Pletal 100mg tabs	
Pletal 50mg tabs	
Non-Preferred Drugs	
Aggrenox	
Ticlid 250mg tabs	
ticlopidine 250mg tabs	

(Continued)

Table 5 – IHCP Preferred Drug List, Blood Products

Preferred Drugs	
Fragmin (pre-filled syringes only)	
heparin (generic products)	
Lovenox (pre-filled syringes only)	
Non-Preferred Drugs	
Arixtra	
Fragmin (formulations other than pre-filled syringes only)	
Innohep	
Preferred Drugs	
gemfibrozil (all formulations)	
TriCor 160mg, 200mg tabs (patients taking other doses of Tricor grandfathered)	
Lofibra 200 tabs	
Zetia	Step edit; patients with current statin therapy may receive Zetia to augment therapy
Non-Preferred Drugs	
Lopid*	
TriCor 54 mg, 67 mg tabs	
Preferred Drugs	
Aranesp	
Epogen	
Procrit	
Non-Preferred Drugs	
None	
Preferred Drugs	
Neupogen (vials only)	
Leukine (vials only)	

(Continued)

Table 5 – IHCP Preferred Drug List, Blood Products

Non-Preferred Drugs	
Neupogen (prefilled syringes)	
Neulasta (vials and syringes)	

Table 6 – IHCP Preferred Drug List, Nervous System

Preferred Drugs	
Axert	1 box-6 tablets per month
Imitrex 5mg nasal spray	1 box-6 inhalers, 6mls/mo
Imitrex 20mg nasal spray	1 box-6 inhalers, 6mls/mo
Imitrex 25mg tabs	1 box-9 tablets per month
Imitrex 50mg tabs	1 box-9 tablets per month
Imitrex 100mg tabs	1 box-9 tablets per month
Imitrex stat dose refill	1 box-2 injections per month
Imitrex vial	2 vials-2 injections per month
Non-Preferred Drugs	
Amerge	
Frova	
Maxalt	
Maxalt MLT	
Zomig	
Zomig ZMT	
Preferred Drugs	
Kytril	10 tabs per prescription
Zofran	10 tabs per prescription
Emend	6 tabs per prescription
Non-Preferred Drugs	
Anzemet	10 tabs per prescription

(Continued)

Table 6 – IHCP Preferred Drug List, Nervous System

Preferred Drugs	
methocarbamol	
cyclobenazprine	
baclofen	
chlorzoxazone	
orphenadrine citrate	
tizanidine	
Dantrium	
Non-Preferred Drugs	
Robaxin*	
Flexeril*	
Lioresal*	
Paraflex, Parafon Forte*	
Norflex, Norgesic Forte*	
Zanaflex*	
Skelaxin	
Soma including combination products	
carisprodol including combination products	

Table 7 – IHCP Preferred Drug List, Gastrointestinal System

+Beginning September 12, 2003, proton pump inhibitors must go through the H2 Receptor Blocker step edit. Patients must fail an H2 Receptor Blocker within the previous six months. All patients with a proton pump inhibitor prior authorization are not subject to the step edit. Proton pump inhibitors were re-reviewed at the June 20, 2003, DUR Board meeting and are effective September 12, 2003.	
Protonix 40mg tabs	Limited to 30 units every 30 days
omeprazole 20mg (generic products)	Limited to 30 units every 30 days
Non-Preferred Drugs	
Aciphex 20mg tabs	
Nexium	All strengths
Prevacid 15mg caps	
Prevacid 30mg caps	
Prevacid Solutab	
Prevacid suspension	All strengths
Prilosec 10mg caps	
Prilosec 20mg caps*	
Prilosec 40mg caps	
Protonix 20mg tabs	
Protonix IV 40mg vial	
Preferred Drugs	
None	
Non-Preferred Drugs	
Helidac	
Prevpac	
Preferred Drugs	
cholestyramine multi-dose containers	
LoCholest powder	
PrevaLite powder	
Cholestid multi-dose containers	

(Continued)

Table 7 – IHCP Preferred Drug List, Gastrointestinal System

Non-Preferred Drugs	
Questran*	
PrevaLite packets	
Cholestid tabs, granule packets	
Welchol	

Table 8 – IHCP Preferred Drug List, Ophthalmics

Preferred Drugs	
Livostin	
Patanol (no grandfathering)	Step edit; must have failed Livostin, Alomide, or cromolyn in last 12 months
Optivar (no grandfathering)	Step edit; must have failed Livostatin, Alomide, or cromolyn in last 12 months
Zaditor (no grandfathering)	Step edit; must have failed Livostatin, Alomide, or cromolyn in last 12 months
Non-Preferred Drugs	
Emadine	
Preferred Drugs	
Alomide	
Cromolyn	
Non-Preferred Drugs	
Alamast	
Alocril	
Crolom	
Opticrom	
Preferred Drugs	
Betaxol	
Levobunolol	

(Continued)

Table 8 – IHCP Preferred Drug List, Ophthalmics

Timolol	
Carteolol	
metipranolol	
Epinephrine	
physostigmine	
Pilocarpine	
Xalatan	
Travatan	
Lumigan	
Iopidine	
Trusopt	
Azopt	
Isopto-Carbachol	
Cosopt	
Non-Preferred Drugs	
Alphagan P	
Betoptic-S	
Betagan	
Timoptic	
Timoptic XE	
Betimol	
Ocuppress	
Optipranolol	
Rescula	
Humorsol	
Isopto-Eserine	
Phospholine Iodide	
Pilocar	
Isopto-Carpine	
Pilopine-HS	
E-Pilo-X	

Table 9 – IHCP Preferred Drug List, Renal System

Preferred Drugs	
bumetanide	All strength and formulations
furosemide	All strength and formulations
torsemide	All strength and formulations
Non-Preferred Drugs	
Bumex*	All strengths
Demadex*	All strengths
Edecrin 25mg tabs	
Edecrin 50mg tabs	
Lasix*	All strengths
Preferred Drugs	
oxybutynin	
Ditropan XL (current patients grandfathered)	Step edit, must fail immediate release product
Detrol LA (current patients grandfathered)	Step edit, must fail immediate release product
Oxytrol	Step edit, must fail immediate release product
Non-Preferred Drugs	
Ditropan*	
Detrol	
Urispas	

Table 10 – IHCP Preferred Drug List, Endocrine System

++Beginning September 12, 2003, thiazolidenediones must go through the metformin step edit. Patients must fail metformin within the previous six weeks. All patients currently taking a thiazolidinedione are not subject to the step edit. Thiazolidinediones were re-reviewed at the June 20, 2003, DUR Board meeting and are effective September 12, 2003.	
Preferred Drugs	
Actos 15mg	Limit 30 tablets per month
Actos 30mg	Limit 30 tablets per month

(Continued)

Table 10 – IHCP Preferred Drug List, Endocrine System

Actos 45mg	Limit 30 tablets per month
Avandia 4mg	Limit 30 tablets per month
Avandia 8 mg	Limit 30 tablets per month
Non-Preferred Drugs	
Avandia 2mg	
Preferred Drugs	
Glyset	
Precose	
Prandin	
Starlix	
glyburide	
metformin	
glipizide, Glucotrol XL	
Amaryl	
Glucovance	Step edit, must fail one of the agents in combo; current tx.g randfathered
MetaGlip	Step edit, must fail one of the agents in combo; current tx. grandfathered
Avandamet	Step edit, must have prior use of metformin within past 60 days
Non-Preferred Drugs	
tolazamide, Tolinase	
tolbutamide, Orinase	
chlorpropamide, Diabenese	
Micronase, Diabeta	
Glucophage, Glucophage XR	
Glucotrol	

Table 11 – IHCP Preferred Drug List, Skin

Preferred Drugs	
Accutane	Preferred for patients 25 years of age or younger
Non-Preferred Drugs	
None	
Preferred Drugs	
all generic tretinoin products	Preferred for patients 25 years of age or younger
Retin-A	Preferred for patients 25 years of age or younger
Differin (step edit)	Step edit, must fail tretinoin product within last year
Non-Preferred Drugs	
Avita	
Preferred Drugs	
Dovonex	
Dithrocream HP	
Oxsoralen-Ultra	
Psoriatic	
Soriatane	
Tazorac	
Non-Preferred Drugs	
None	

Table 12 – IHCP Preferred Drug List, Analgesics

Preferred Drugs	
Products containing acetaminophen are limited to three grams of acetaminophen per day	
all generic products	
acetaminophen/codeine #2, 3, 4	

(Continued)

Table 12 – IHCP Preferred Drug List, Analgesics

aspirin with codeine	
oxycodone	
hydromorphone	
pentazocine	
tramadol	Limit 400mg per day
hydrocodone (all formulations)	Limit 1500mg per month
propoxyphene	
Duragesic	Limit 10 patches per 30 days
Oxycontin	Limit 120 tablets per 25 days
Oxycontin 80mg	Limit 60 tablets per 25 days
butorphanol	Limit one vial per month
Non-Preferred Drugs	
Tylenol #2,3,4	
Empirin	
Percocet, Percodan	
Dilaudid	
Talwin	
Ultram	
Lorcet, Maxidone, Norco, Zydone, Vicoprofen, Lortab, Vicodan	
Darvon, Wygesic	
Kadian	
Actiq	
Stadol NS	
Ultracet	

Table 13 – IHCP Preferred Drug List, Bone Agents

Preferred Drugs	
Actonel	
Evista	

(Continued)

Table 13 – IHCP Preferred Drug List, Bone Agents

etidronate disodium generic products	
Fosamax (weekly formulations)	
Non-Preferred Drugs	
Didronel	
Fosamax (daily formulations)	
Miacalcin	
Skelid	
Preferred Drugs	
None	
Non-Preferred Drugs	
Forteo	

Table 14 – IHCP Preferred Drug List, Genitourinary System

Preferred Drugs	
Flomax	
Proscar	
Avodart	
Non-Preferred Drugs	
None	
Preferred Drugs	
Estrace Vaginal Cream	
Estring	
Ogen	
Ortho-Dienestrol	
Premarin Vaginal Cream	
Vagifem	

(Continued)

Table 14 – IHCP Preferred Drug List, Genitourinary System

Non-Preferred Drugs	
None	
Preferred Drugs	
clotrimazole	
miconazole	
tioconazole	
Non-Preferred Drugs	
Cleocin Vaginal	Cream/ovule
Gynazole 1	
Gyne-Lotrimin	
Metrogel Vaginal	
Monistat	
Mycelex	
Terazole	
Vagistat-1	

Table 15 – IHCP Preferred Drug List, Smoking Cessation

Preferred Drugs	
nicotine patch	
Nicotrol NS	
Nicotrol Inhaler	
nicotine gum	
Commit lozenge	
Non-Preferred Drugs	
Nicoderm	
Habitrol	
Nicotrol	
Nicorette	
Nicorette DS	

Prior authorization for brand medically necessary is not required for the drugs specifically exempted by the DUR Board from a prior authorization for brand medically necessary requirement, for example those drugs that are typically referred to as narrow therapeutic index drugs.

Brand name medications with a generic available are non-PDL, when a brand name drug having generic equivalents is included in the **Non-Preferred Drug List the generic equivalents for the brand name drug are considered as being **on PDL**, and therefore, do not require prior approval.*

***In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and "cross indicated" drugs are considered on the PDL. Also included on the PDL are drugs that are classified in a central nervous system drug category or classification, according to Drug Facts and Comparisons, that is created after March 12, 2002, and prescribed for the treatment of a mental illness, as defined by the most recent publication of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.*

Note: Prior authorization is required for all non-preferred drugs and/or requests for quantities of drugs that exceed the State limit.

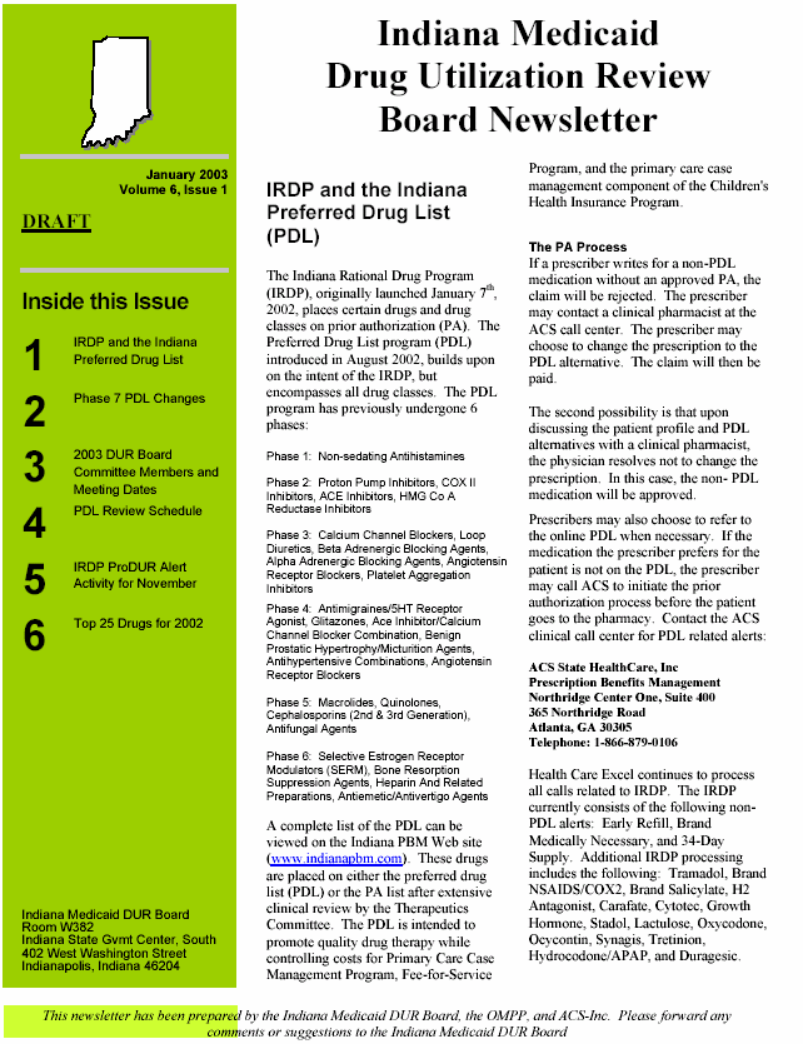
Additional Information

Please direct all questions about the PDL and prior authorization needed for non-PDL drugs to the ACS-State Health Care Clinical Call Center at 1-866-879-0106. Please direct any questions about IRDP or ProDUR prior authorizations to the Health Care Excel (HCE) Prior Authorization Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518. Please direct questions about this bulletin to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 4.5 DUR BOARD NEWSLETTERS

JANUARY 2003, JUNE 2003, AND OCTOBER 2003



January 2003
Volume 6, Issue 1

DRAFT

Inside this Issue

Indiana Medicaid DUR Board
Room W382
Indiana State Gvmt Center, South
402 West Washington Street
Indianapolis, Indiana 46204

Indiana Medicaid Drug Utilization Review Board Newsletter

IRDP and the Indiana Preferred Drug List (PDL)

The Indiana Rational Drug Program (IRDP), originally launched January 7th, 2002, places certain drugs and drug classes on prior authorization (PA). The Preferred Drug List program (PDL) introduced in August 2002, builds upon on the intent of the IRDP, but encompasses all drug classes. The PDL program has previously undergone 6 phases:

Phase 1: Non-sedating Antihistamines

Phase 2: Proton Pump Inhibitors, COX II Inhibitors, ACE Inhibitors, HMG Co A Reductase Inhibitors

Phase 3: Calcium Channel Blockers, Loop Diuretics, Beta Adrenergic Blocking Agents, Alpha Adrenergic Blocking Agents, Angiotensin Receptor Blockers, Platelet Aggregation Inhibitors

Phase 4: Antimigraines/5HT Receptor Agonist, Glitazones, Ace Inhibitor/Calcium Channel Blocker Combination, Benign Prostatic Hypertrophy/Micturition Agents, Antihypertensive Combinations, Angiotensin Receptor Blockers

Phase 5: Macrolides, Quinolones, Cephalosporins (2nd & 3rd Generation), Antifungal Agents

Phase 6: Selective Estrogen Receptor Modulators (SERM), Bone Resorption Suppression Agents, Heparin And Related Preparations, Antiemetic/Antivertigo Agents

A complete list of the PDL can be viewed on the Indiana PBM Web site (www.indianapbm.com). These drugs are placed on either the preferred drug list (PDL) or the PA list after extensive clinical review by the Therapeutics Committee. The PDL is intended to promote quality drug therapy while controlling costs for Primary Care Case Management Program, Fee-for-Service Program, and the primary care case management component of the Children's Health Insurance Program.

The PA Process

If a prescriber writes for a non-PDL medication without an approved PA, the claim will be rejected. The prescriber may contact a clinical pharmacist at the ACS call center. The prescriber may choose to change the prescription to the PDL alternative. The claim will then be paid.

The second possibility is that upon discussing the patient profile and PDL alternatives with a clinical pharmacist, the physician resolves not to change the prescription. In this case, the non- PDL medication will be approved.

Prescribers may also choose to refer to the online PDL when necessary. If the medication the prescriber prefers for the patient is not on the PDL, the prescriber may call ACS to initiate the prior authorization process before the patient goes to the pharmacy. Contact the ACS clinical call center for PDL related alerts:

ACS State HealthCare, Inc
Prescription Benefits Management
Northridge Center One, Suite 400
365 Northridge Road
Atlanta, GA 30305
Telephone: 1-866-879-0106

Health Care Excel continues to process all calls related to IRDP. The IRDP currently consists of the following non-PDL alerts: Early Refill, Brand Medically Necessary, and 34-Day Supply. Additional IRDP processing includes the following: Tramadol, Brand NSAIDS/COX2, Brand Salicylate, H2 Antagonist, Carafate, Cytotec, Growth Hormone, Stadol, Lactulose, Oxycodone, Oecycontin, Synagis, Tretinion, Hydrocodone/APAP, and Duragesic.

This newsletter has been prepared by the Indiana Medicaid DUR Board, the OMPP, and ACS-Inc. Please forward any comments or suggestions to the Indiana Medicaid DUR Board

The prior approval form required for IRDP related alerts may be downloaded from www.indianamedicaid.com. Prescribers and their authorized office personnel may submit requests via telephone, fax, or mail using the following information:

Health Care Excel
Prior Authorization Department
Attn: Indiana Rational Drug Program
2629 Waterfront Pkwy East Dr., Suite 200
Indianapolis, IN 46214
Telephone: (317) 347-4511
Fax: (317) 347-3593
Toll Free: (800) 457-4518

Phase 7 PDL

On December 20th, 2002, the Indiana Medicaid DUR Board approved the 7th Phase of the Preferred Drug List (PDL) program. Phase 7 of the PDL is to be implemented on February 26th, 2003. The drug classes reviewed for Phase 7 include: medications used to treat osteoporosis (Selective Estrogen Receptor Modulators and Bone Resorption Suppression Agents), Heparin and related products, and Anticmetic/Antivertigo agents. Additionally, Phase 7 adds quantity limits for prescriptions written for Zofran®, Kytril®, and the non-PDL medication Anzmet®. The PDL additions are listed in table 6.1.

Table 6.1

SERMs/Bone Resorption Supp Agents	*Heparin & Related Products*	*Antiemetic & Antivertigo Agents**
Actonel	heparin: all generic forms	Zofran
Fosamax Weeky	Fragmin pre-filled syringe	Kytril
Evista	Lovenox pre-filled syringe	
etidronate disodium		

*limit 10 tabs or 1 bottle oral solution/prescription

Questions About the PDL
Providers who wish to know more about the PDL are encouraged to refer to IHCP Bulletins BT200235, BT200243, BT200246, BT200247, BT200255, and BT200261. Copies of the bulletins are available on the IHCP Web site at www.indianamedicaid.com. The Indiana PBM Web site (www.indianapbm.com), contains specific information about the PDL and the PDL program. Questions about the bulletins or the PDL are to be directed to the ACS – State Health Care Clinical Call Center at **1-866-879-0106**.

The 2003 DUR Board Members

The 2003 DUR Board members are as follows. Individuals noted with an asterisk are new members of the Board.

Terry Lindstrom, Ph.D.
Chairperson, Pharmacologist

John J. Wernert, M.D.
Vice-Chairperson, Physician

Patricia Treadwell, M.D.
Physician

Marc Shirley, R.Ph.
OMPP Representative-Ex Officio

Neil Irick, M.D.
Physician

Phillip N. Eskew, Jr., M.D.
Physician

G. Thomas Wilson, B.S. Pharm., J.D.
Pharmacist

Thomas A. Smith, P.D., M.S.
Pharmacist

Paula J. Ceh, Pharm.D.
Pharmacist

Brian Musial, R.Ph.
Pharmacist

Marko Mychaskiw, R.Ph., Ph.D.
Health Economist

Vicki Perry
HMO Representative

DUR Board meetings are scheduled at 9:30 am on the third Friday of each month. Dates, locations, and agendas for upcoming meetings are published on the DUR Board Web site. The Web site also allows readers to submit comments to the Board via e-mail. To access the DUR Board Web site, go to the IHCP Web site at www.IndianaMedicaid.com. Position the cursor to the Pharmacy Services button, found on the top bar of the IHCP's homepage, to highlight menu selections. Readers can access information pertaining to bulletins and the latest news involving the IHCP pharmacy benefit, as well as DUR Board information, by clicking the appropriate listing from the menu.

DUR Board 2003 Meeting Dates:

- **January 17, 2003**
- **February 23, 2003**
- **March 21, 2003**
- **April 25, 2003**
- **May 16, 2003**
- **June 20, 2003**
- **July 18, 2003**
- **August 15, 2003**
- **September 19, 2003**
- **October 17, 2003**
- **November 21, 2003**
- **December 19, 2003**

PDL Review Schedule

A tentative schedule of drug classes for review is on the www.IndianaPBM.com Web site. The following classes are scheduled for the February review:

Skeletal Muscle Relaxants (H6H)
Urinary Tract Antispasmodic/Antiincontinence (R1A)
Biguanides/Other Hypoglycemic Agents (CK4)
Brand Name Narcotics (H3A)
Fibric Acids (M4E)
Bile Acid Sequestrants (D7L)

IRDP ProDUR Alert Activity for November

On December 20th, 2002, the Indiana Medicaid DUR Board was presented a report of Indiana Rational Drug Program ProDUR alert activity occurring during November 1st to November 30th, 2002. The following information was contained in the report:

For the month, 7,571 ProDUR alerts were issued on pharmacy claims submitted via Point-of-Sale. PA overrides were submitted for 6,585 of those alerts (87 percent). Table 6.2 shows the top 6 alert categories including total number of alerts, alerts approved, alerts denied and the number of alerts suspended.

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Table 6.2

Category	Total Number of alerts	Approved	Denied	Suspended
Tramadol	209	125	25	59
Brand COX2 /NSAIDS	494	329	27	138
H2 Antagonists	130	103	6	21
Synagis	144	131	12	1
Early Refill	6024	5590	349	85
Duragesic	113	103	6	4

Changes to the IHCP ProDUR System

Starting January 15, 2003, IHCP's online ProDUR system will be modified to screen prescription claims in the following manner:

Drug-Drug Interaction Edit
A Severity Level 1 drug-drug interaction occurs when a patient has been prescribed two or more medications that are contraindicated for simultaneous use and may result in serious harm or death for the patient. Effective January 15th, 2003, claims that post a drug-drug alert (based on data taken from First DataBank), will be denied.

Pharmacists will not be permitted to override the alert unless prior authorization is obtained. PA will be granted when an extenuating circumstance exists to substantiate the need to dispense products that are contraindicated for simultaneous use, or where one of the drugs has actually been discontinued (false-positive). The dispensing pharmacist will be allowed to obtain a PA when a false-positive Severity Level 1 drug-drug interaction exists.

High Dose Edit
High Dose has been defined by the Indiana DUR Board as a dose that exceeds the recommended dosage based on criteria published by First DataBank. Starting March 6th, 2003, all claims posting the high dose edit will require the pharmacy provider to call the appropriate help desk for prior approval. The following therapeutic classes are the only therapeutic classes exempt at this time since they are presently screened by IRDP:

- Hydrocodone / APAP
- Oxycodone / APAP
- Oxycodone

In addition, there are some drugs or drugs classes which the dispensing pharmacist can override (disposition A) at the point-of-sale. These drugs/classes are listed in table 6.3.

Table 6.3
Drugs /Classes with Disposition A

J5D Beta-Adrenergic Agents
Q8B Ear Preparations, Misc. Anti-infectives
Q8W Ear Preparations, Antibiotics
Q8H Ear Preparations, Local Anesthetics
Q6I Eye Antibiotic-Corticoid Combinations
Q6R Eye Antihistamines
Q6P Eye Anti-inflammatory Agents
Q6V Eye Antivirals
Q6H Eye Local Anesthetics
Q6S Eye Sulfonamides
Q6C Eye Vasoconstrictors (RX Only)
Q6G Miotics/Other Intraoc. Pressure Reducers
H2L, H2O Anti-Psychotics, Non-Phenothiazines
H2G, H2I Anti-Psychotics, Phenothiazines
H4B, H4C Anticonvulsants
H7P Antipsychotics, Atypical, Dopamine, & Serotonin Antagonists
H2D Barbiturates
A9A Calcium Channel Blocking Agents
Q6W Ophthalmic Antibiotics
Q6U Ophthalmic Mast Cell Stabilizers
Q6A Ophthalmic Preparations, Miscellaneous
H2F, H2P Anti-Anxiety Drugs
H2M Anti-Mania Drugs
H2V Anti-Narcolepsy/Anti-Hyperkinesis Agents
H2A Central Nervous System Stimulants
J1B Cholinesterase Inhibitors
Guanfacine HCl
Clonidine HCl
H2H, H7L, H7K, H7J Monoamine Oxidase (MAO) Inhibitors
H2E, H2Q Sedative-Hypnotics, Non-Barbiturate
H2S, H7H Serotonin Specific Reuptake Inhibitors
H7E Serotonin-2 Antagonist/Reuptake Inhibitors
H7C Serotonin-Norepinephrine Reuptake-Inhibit
H2X Tricyclic Antidepressant/Benzodiazepine Combinations
H2W Tricyclic Antidepressant/Phenothiazine Combinations
H2U Tricyclic Antidepressants & Rel. Non-Sel. Reuptake Inhibitors

Indiana Medicaid DUR Board Newsletter

Top 25 Drugs Classes for 2002

The Antipsychotics, Atypical, Dopamine, & Seratonin Antagonists drug class accounted for the highest dollar amount paid for prescription drug services dispensed to non-risk based IHCP members. Table 6.4 lists the drug classes ranked by total amount paid.

Table 6.4
2002 Top 25 Drug Classes by Total Amount Paid

Rank	Drug Class	Paid Units	Amount Paid
1	Antipsychotics, Atypical, Dopamine, & Serotonin Antagonist	390979	$74,545,984.25
2	Anticonvulsants	480391	$36,727,000.40
3	Serotonin Specific Reuptake Inhibitors (SSRIs)	418380	$33,733,197.24
4	Gastric Acid Secretion reducers	391601	$30,125,529.59
5	Analgesics, Narcotics	759155	$26,899,352.87
6	Lipotropics	203352	$16,649,168.05
7	Antihistamines	394679	$15,586,366.10
8	NSAIDS, Cycooxygenase Inhibitor	316574	$12,043,220.97
9	Antihemophilic Factors	1816	$11,760,182.99
10	Beta-Adrenergic Agents	321442	$10,767,760.35
11	Calcuim Channel Blocking Agents	202259	$9,473,666.75
12	Insulins	146809	$7,964,929.02
13	Penicillins	336042	$7,933,683.89
14	Hypotensives, ACE Blocking Type	227389	$7,610,978.91
15	Hypoglycemics, Insulin-Response Enhancers (NS)	60579	$7,393,877.22
16	Anti-anxiety	322910	$7,334,027.18
17	Glucocorticoids	182740	$7,011,624.83
18	Anti-narcolepsy / Anti-hyperkinsesis Agents	114927	$6,690,760.78
19	Platelet Aggregation Inhibitors	67649	$6,506,998.41
20	Quinolones	92567	$6,236,274.16
21	Macrolides	162406	$6,193,082.70
22	Cholinesterase Inhibitors	50600	$6,067,640.89
23	Blood Sugar Diagnostics	77655	$5,918,388.72
24	Adrenergics, Aromatic, Non-Catecholamine	66140	$5,719,775.33
25	Antimigraine Preparations	45648	$5,693,426.36

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June 2003
Volume 6, Issue 2

Inside this Issue

Indiana Medicaid DUR Board
Room W382
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402 West Washington Street
Indianapolis, Indiana 46204

Indiana Medicaid Drug Utilization Review Board Newsletter

IRDP and the Indiana Preferred Drug List (PDL)

The Indiana Rational Drug Program (IRDP), originally launched January 7th, 2002, places certain drugs and drug classes on prior authorization (PA). The Preferred Drug List (PDL) program introduced in August 2002 builds on the intent of the IRDP. Since the last issue of the Drug Utilization Review (DUR) Board Newsletter the initial Indiana Preferred Drug List review has been completed with three more phases added to the Indiana PDL:

Phase 8: Bile Acid Sequestrants, Fibric Acids, Skeletal Muscle Relaxants, Urinary Tract Antispasmodics, Brand Name Narcotics, Antidiabetic Agents

Phase 9: Ophthalmic Mast Cell Stabilizers, Eye Antihistamines, Miotics and other Intraocular Pressure Reducers, Ophthalmic Antibiotics, Otic Antibiotics, Vitamin A Derivatives, Antipsoriatics, Leukocyte Stimulants, Hematinics, Ultracet, Forteo, Smoking Deterrent Agents

Phase 10: Antiviral (Influenza) Agents, Antiviral (Antiherpetic) Agents, Topical Antifungals, Oral Antifungals, Vaginal Antimicrobials, Topical Estrogen Agents, Anti-Ulcer/H. Pylori Agents

A complete list of the PDL can be viewed on the Indiana PBM Web site (www.indianapbm.com). These drugs are placed on either the PDL or the PA list after extensive clinical review by the Therapeutics Committee and DUR Board approval. Some drug classes have not been reviewed for PDL status. The drugs in these classes are not subject to the PA or the PDL edits. The PDL is intended to promote quality drug therapy while controlling costs for Primary Care Case Management Program, Fee-for-Service Program, and the primary care case management component of the Children's Health Insurance Program.

The PA Process

If a prescriber writes for a non-PDL medication without an approved PA, the claim will be rejected. The prescriber may contact a clinical pharmacist at the ACS call center. The prescriber may choose to change the prescription to the PDL alternative. The claim will then be paid.

The second possibility is that upon discussing the patient profile and PDL alternatives with a clinical pharmacist, the physician resolves not to change the prescription. In this case, the non- PDL medication will be approved.

Prescribers may also choose to refer to the online PDL when necessary. If the medication the prescriber selects for the patient is not on the PDL, the prescriber may call ACS to initiate the prior authorization process before the patient goes to the pharmacy. Contact the ACS clinical call center for PDL related alerts:

ACS State HealthCare, Inc
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Telephone: 1-866-879-0106

Health Care Excel continues to process all calls related to IRDP. The IRDP currently consists of the following non-PDL alerts: Early Refill, High Dose Alerts, Drug-Drug Severity Level 1 Alerts, Brand Medically Necessary, and 34-Day Supply. Additional IRDP processing includes the following: Brand NSAIDS/COX2, Brand Salicylate, H2 Antagonist, Carafate, Cytotec, Growth Hormone, Lactulose, and Synagis.

The prior approval form required for IRDP related alerts is downloadable from

This newsletter has been prepared by the Indiana Medicaid DUR Board, the OMPP, and ACS-Inc. Please forward any comments or suggestions to the Indiana Medicaid DUR Board

www.indianamedicaid.com. Prescribers and their authorized office personnel may submit requests via telephone, fax, or mail using the following information:

Health Care Excel
Prior Authorization Department
Attn: Indiana Rational Drug Program
2629 Waterfront Pkwy East Dr., Suite 200
Indianapolis, IN 46214
Telephone: (317) 347-4511
Fax: (317) 347-3593
Toll Free: (800) 457-4518

Semi-Annual PDL Re-Review Schedule

A complete re-review of the Indiana Preferred Drug List by the Therapeutics Committee is scheduled to take place on the following dates:

- August 1, 2003
- November 7, 2003

The Proton Pump Inhibitors and the Thiazolidinediones will not be included in the August re-review due to the re-review of these classes at the June 6, 2003 Therapeutics Committee meeting.

Questions About the PDL

Providers who wish to know more about the PDL are encouraged to refer to the Indiana PBM Web site, www.indianapbm.com. The Indiana PBM website contains specific information about the PDL and the PDL process.

Also, PDL bulletins can be found at www.indianamedicaid.com. For questions about the PDL, please call the ACS – State Health Care Clinical Call Center at **1-866-879-0106**.

DUR Board Members

The 2003 DUR Board members are as follows:

Terry Lindstrom, Ph.D.
Chairperson, Pharmacologist

John J. Wernert, M.D.
Vice-Chairperson, Physician

Patricia Treadwell, M.D.
Physician

Marc Shirley, R.Ph.
OMPP Representative-Ex Officio

Neil Irick, M.D.
Physician

Philip N. Eskew, Jr., M.D.
Physician

G. Thomas Wilson, B.S. Pharm., J.D.
Pharmacist

Thomas A. Smith, P.D., M.S.
Pharmacist

Paula J. Ceh, Pharm.D.
Pharmacist

Brian Musial, R.Ph.
Pharmacist

Marko Mychaskiw, R.Ph., Ph.D.
Health Economist

Vicki Perry
HMO Representative

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Changes to the IHCP ProDUR System

Starting July 21, 2003, IHCP's online ProDUR system will be modified to screen prescription claims in the following manner:

Therapeutic Duplication ProDUR Edit

Therapeutic duplication is defined as the use or prescribing of two or more drug products of the same therapeutic class, based on criteria published by First DataBank. Effective July 21st, therapeutic duplication alerts for Angiotensin Converting Enzyme Inhibitors (ACE Inhibitors) and Angiotensin Receptor Blockers (ARBs) will require prior authorization.

Pharmacists will not be permitted to override the alert unless prior authorization is obtained. Pharmacists can obtain a prior authorization from Health Care Excel (HCE) when one of the drugs has been discontinued. Prescribers must obtain prior authorization from HCE when multiple products in the same therapeutic class are being dispensed. Clinical rationale for therapeutic duplication is required to support the prior authorization request. The prior authorization forms are available on the IHCP website at www.indianamedicaid.com.

Prescribers and pharmacists can contact Health Care Excel by telephone, fax or mail using the following information:

Health Care Excel
Prior Authorization Department
Attn: Indiana Rational Drug Program
2629 Waterfront Pkwy East Dr., Suite 200
Indianapolis, IN 46214
Telephone: (317) 347-4511
Fax: (317) 347-3593
Toll Free: (800) 457-4518

Top 25 Drugs First Quarter 2003

The following table lists the drugs ranked by total amount paid for the first quarter of 2003for prescriptions dispensed to non-risk based IHCP members.

Top 25 Drugs by Total Amount Paid

DRUG	CLAIMS PAID	TOTAL PAID
ZYPREXA	33,782	$9,718,727
RISPERDAL	35,546	$5,922,331
PROTONIX	42,277	$3,928,077
SEROQUEL	20,743	$3,726,504
DEPAKOTE	28,475	$3,008,309
NEURONTIN	23,997	$2,738,664
ZOLOFT	31,735	$2,648,787
LIPITOR	28,773	$2,379,948
PAXIL	24,963	$2,107,689
NOVOSEVEN	237	$2,049,664
ALLEGRA	32,959	$1,992,021
DURAGESIC	11,890	$1,977,368
OXYCONTIN	10,487	$1,888,051
PLAVIX	16,460	$1,804,332
ZOCOR	13,781	$1,594,170
TOPAMAX	9,021	$1,589,230
EFFEXOR	15,473	$1,535,724
ACTOS	8,530	$1,485,731
CONCERTA	22,953	$1,408,345
ZITHROMAX	35,404	$1,371,978
AUGMENTIN	21,227	$1,368,312
WELLBUTRIN	15,068	$1,355,786
CELEXA	17,946	$1,312,127
REMERON	18,274	$1,310,277
ADVAIR	9,558	$1,274,225

October 2003
Volume 6, Issue 3

DRAFT

Inside this Issue

Indiana Medicaid DUR Board
Room W382
Indiana State Gvmt Center, South
402 West Washington Street
Indianapolis, Indiana 46204

Indiana Medicaid Drug Utilization Review Board Newsletter

Clinical Topic 1:

Common Cold and Flu

Each year millions of Americans present symptoms of the common cold or flu at the physician's office and receive antibiotic treatment. However, viruses are the cause of the common cold and flu. The usage of antibiotics, in most cases, provides more psychological comfort for patients than actual effects against the disease. In fact, over-the-counter medications and/or vaccination are sufficient to combat the cold and flu.

Based on statistics from the American Lung Association, children have about 6-8 colds a year, and adults average 2-4 colds a year. There are more than 200 different viruses known to cause symptoms of the common cold. Rhinoviruses are responsible for more than half of the colds, but they seldom produce serious illnesses. Other viruses, such as parainfluenza and respiratory syncytial virus, may produce mild infections in adults and more severe lower respiratory infections in young children. The general principle in treating common colds is symptom relief, which can be achieved by antihistamines for sneezing and runny nose (such as chlorpheniramine tablets and syrup, diphenhydramine capsules and elixir), analgesics for aches and fever (acetaminophen, ibuprofen), decongestants for stuffy nose (pseudoephedrine), or cough suppressants (guaifenesin with dextromethorphan).

Flu is a more severe illness than the common cold. Unlike the common cold, influenza typically causes fever, muscle aches, and a more severe cough. However, symptoms of mild cases of influenza are similar to colds. Each year, influenza affects 10 to 20% of the U.S. population. Vaccination is the primary measure for preventing morbidity and mortality from influenza. The American Academy of Family Physicians and American Academy of Pediatrics recommended that adults aged 50 years or older and children aged 6 to 18 months receive an annual influenza vaccination. High risk individuals aged 19 to 49 years should also receive the immunization. High-risk individuals include, but are not limited to, asthma patients, patients with chronic disorders requiring frequent medical follow-up (such as diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression), women who are in the second or third trimester of pregnancy during the influenza season, and health care workers. The vaccines are available as an injection as well as the recently approved intranasal spray, FluMist. Antiviral treatments such as amantadine, rimantadine and neuraminidase inhibitors (Relenza and Tamiflu) are additional tools to treat influenza. However, for these drugs to be effective the diagnosis must be made and treatment must be initiated within 48 hours of symptom onset.

Despite the lack of evidence supporting the efficacy of antibiotic agents in treating cold and flu, antibiotics are still frequently prescribed for patients presenting such symptoms. Far from being a harmless practice, prescribing antibiotics for conditions that have no proven benefit of such therapy contributes to serious consequences: the development of antimicrobial resistance and an unnecessary cost to patients and health care system. Today, avoidance of inappropriate antibiotic use and prevention of antibiotic resistance are among the top concerns of public health officials. After decades of antibiotic research and development, we are still engaged in the very same battle with

This newsletter has been prepared by the Indiana Medicaid DUR Board, the OMPP, and ACS-Inc. Please forward any comments or suggestions to the Indiana Medicaid DUR Board

bacteria. Many bacterial infections in the United States and throughout the world are becoming resistant to antibiotic therapy. The Center for Disease Control and Prevention (CDC) has launched a campaign to fight antibiotic resistance. The following websites provide information for the CDC program and practice guidelines:

- Promoting Appropriate Antibiotic Use in the Community http://www.cdc.gov/drugresistance/community/
- Active Bacterial Core Surveillance (ABCs) http://www.cdc.gov/abcs
- National Immunization Program http://www.cdc.gov/nip
- Principles of Judicious Use of Antimicrobial Agents for Pediatric Upper Respiratory Tract Infections http://pediatrics.aappublications.org/cgi/content/full/101/1/S1/163?ijkey=r6Ue0RunMrG/Q&keytype=ref&siteid=pediatrics
- Principles of Appropriate Antibiotic Use for Treatment of Acute Respiratory Tract Infections in Adults: Background, Specific Aims, and Methods http://www.annals.org/cgi/content/full/134/6/479

Clinical Topic 2:

Appropriate Use of Skeletal Muscle Relaxants

Skeletal muscle relaxants (SMRs) are indicated for the treatment of muscle spasm and spasticity. The mechanisms of action of the agents in this class are widely varied, and many are not thoroughly understood. One method by which SMRs exert an effect is interneuronal blockade at the level of the spinal cord. Additionally, these agents have CNS depressant properties that may contribute to, or are mainly responsible for, the skeletal muscle relaxant activity. The CNS depressive mechanism also limits this class' use due to a high incidence of sedation.

Baclofen, carisoprodol, chlorzoxazone, cyclobenzaprine, metaxalone, methocarbamol and orphenadrine all have the indication to treat muscle spasm. For most of the agents, treatment of muscle spasm should be limited to two or three weeks. It is important to encourage proper utilization of these agents because skeletal muscle relaxants, such as carisoprodol and methocarbamol, have been associated with abuse and addiction; therefore, patients should adhere to the suggested dosages for these agents (Table 1). Baclofen, dantrolene and tizanidine have the indication to treat spasticity. These agents may be used for longer periods of time and may play a role in improving the functional status of patients as well as managing the symptoms associated with spasticity. More evidence is warranted to establish whether these agents consistently modify overall disability or improve quality of life.

Although some of these agents (e.g., metaxalone) are presumed to have less pronounced sedative effects than others, all of the SMRs are capable of producing some degree of CNS depression. Potentially hazardous tasks and tasks requiring alertness and/or coordination (such as driving and athletics) should be avoided by patients who are using these drugs. Concomitant use of alcohol or other CNS depressants should be avoided when taking any of these medications.

Skeletal muscle relaxants are a class of drugs whose place in therapy is disputed due to their adverse effect profile and lack of well-designed studies to demonstrate consistent improvement in patients' functional status. These medications can be efficacious when used judiciously. They should not be a substitute for rest, exercise, physical therapy or proper doses of effective analgesics, but rather serve as adjunctive, short-term therapy. Additionally, there is little evidence that demonstrates additional benefit of combination SMR therapy; therefore, concurrent use of multiple muscle relaxants should be avoided. Providers should monitor for adverse effects, abuse, and tolerance in patients.

Table 1. Appropriate dosage and administration of skeletal muscle relaxants

Drug	Adult Dosage and Administration
Baclofen	Titrate slowly up to 40-80 mg/day po given in 3-4 divided doses.
Carisoprodol	350 mg 3 or 4 times daily; take the last dose at bedtime.
Chlorzoxazone	250-500 mg given TID-QID; doses up to 750 mg TID-QID may be given for severe muscle spasm.
Cyclobenzaprine HCl	5-10 mg TID; do not exceed 60 mg/day. Do not use longer than 2 or 3 weeks.
Dantrolene sodium	25-100 mg BID-QID; maximum dosage is 400 mg/day.
Metaxalone	800 mg TID-QID
Methocarbamol	1.5 g QID for 2-3 days
Orphenadrine citrate	100 mg QAM and QPM
Tizanidine HCl	8 mg TID-QID; maximum dosage is 36 mg/day.

Preferred Drug List Re-review

PDL Re-Review Schedule

A complete re-review of the Indiana Preferred Drug List by the Therapeutics Committee is scheduled to take place on the following dates:

- November 7, 2003
- February 4, 2004

Questions About the PDL

Providers who wish to know more about the PDL are encouraged to refer to the Indiana PBM Web site, www.indianapbm.com. The Indiana PBM website contains specific information about the PDL and the PDL process.

Also, PDL bulletins can be found at www.indianamedicaid.com. For questions about the PDL, please call the ACS – State Health Care Clinical Call Center at **1-866-879-0106**.

DUR Board Members

The 2003 DUR Board members are as follows:

Terry Lindstrom, Ph.D.
Chairperson, Pharmacologist

John J. Wernert, M.D.
Vice-Chairperson, Physician

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Physician

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HMO Representative

The DUR Board meets once a month. Dates, locations, and agendas for upcoming meetings are published on the DUR Board Web site. The Web site also allows readers to submit comments to the Board via e-mail. To access the DUR Board Web site, go to the IHCP Web site at www.indianamedicaid.com. Position the cursor to the Pharmacy Services button, found on the top bar of the IHCP's homepage, to highlight menu selections. Readers can access information pertaining to bulletins and the latest news involving the IHCP pharmacy benefit, as well as DUR Board information, by clicking the appropriate listing from the menu.

Top 25 Drugs Third Quarter 2003

The following table lists the drugs ranked by total amount paid for the first quarter of 2003 for prescriptions dispensed to non-risk based IHCP members.

Top 25 Drugs by Total Amount Paid

DRUG	TOTAL PAID	TOTAL CLAIMS
ZYPREXA	$10,376,406.67	35,174
RISPERDAL	$6,443,106.13	36,362
PROTONIX	$4,724,572.60	49,078
SEROQUEL	$4,644,219.16	24,700
DEPAKOTE (AND GENERIC)	$3,491,265.32	30,813
NEURONTIN (AND GENERIC)	$3,244,837.12	27,306
ZOLOFT	$3,015,944.19	35,383
LIPITOR	$2,970,871.37	35,475
ALLEGRA	$2,550,612.66	41,425
DURAGESIC	$2,502,204.01	13,507
OXYCODONE (OXYCONTIN AND OTHERS)	$2,462,446.84	12,537
PAXIL	$2,180,490.70	25,263
PLAVIX	$2,138,503.73	19,362
NOVOSEVEN	$2,086,110.79	115
ZOCOR	$2,062,319.73	17,624
TOPAMAX	$2,021,046.30	10,921
EFFEXOR (AND XR)	$1,920,779.03	17,694
ABILIFY	$1,864,999.89	6,603
ACTOS	$1,700,458.22	9,661
ADVAIR	$1,633,398.97	11,826
SINGULAIR	$1,624,695.69	20,291
WELLBUTRIN (AND SR, XL)	$1,536,368.37	16,374
ARICEPT	$1,410,486.65	11,194
METHYLEPHENIDATE (CONCERTA AND OTHERS)	$1,386,265.50	21,633
PROZAC (AND GENERICS)	$1,337,509.60	23,261

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

ATTACHMENT 4.6 PDL IMPLEMENTATION SCHEDULE & PDL LIST

INDIANA PDL IMPLEMENTATION SCHEDULE	
Implementation Date	**Therapeutic Class Grouping Description**
8/21/2002	NON-SEDATING ANTIHISTAMINES
9/17/2002	ACE INHIBITORS
	PROTON PUMP INHIBITORS (PPIs)
10/9/2002	CALCIUM CHANNEL BLOCKERS
	BETA ADRENERGIC BLOCKING AGENTS
	ALPHA ADRENERGIC BLOCKING AGENTS
	PLATELET AGGREGATION INHIBITORS
	LOOP DIURETICS
12/10/2002	ACE INHIBITORs w/DIURETIC COMBOS
	ARBs w/DIURETIC COMBO (BUT not ARBs only 1/7/03)
	ACEI/CCB COMBINATIONS
	ARB/CCB COMBOS (None Preferred)
	GLITAZONES (THIAZOLIDINEDIONES)
	ANTIMIGRAINES 5HT1 (TRIPTANS)
	BETA AGONIST (LONG AND SHORT ACTING)
	INHALED CORTICORSTEROIDS
	HMG COA REDUCTASE INHIBITORS
	NASAL CORTICORSTEROIDS
	BPH
	LEUKOTRIENE INHIBITORS
1/7/2003	ARB'S Only
	CEPHALOSPORINS
	MACROLIDES
	QUINOLONES
	CEPHALOSPORINS
	ANTIFUNGAL AGENTS (not Griseofulvin til 8-6-03)
2/26/2003	ANTIEMETIC/ ANTIVERTIGOs
	HEPARIN / RELATED PRODUCTS
	BONE RESORPTION SUPPRESSION AGENTS
	SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERM)
5/14/2003	SKELETAL MUSCLE RELAXANTS
	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE
	BIGUANIDES/OTHER ANTIDIABETIC AGENTS (COMBOS)
	BRAND NAME NARCOTICS
	FIBRIC ACIDS
	BILE ACID SEQUESTRANTS
7/21/2003	LEUKOCYTE (WBC) STIMULANTS
	HEMATINICS,OTHER
	SMOKING DETERRENT AGENTS
	DRUGS TO TREAT IMPOTENCY
	OPHTHALMIC MAST CELL STABILIZERS, EYE ANTIHISTAMINE
	MIOTICS/OTHER INTRAOC. PRESSURE REDUCERS
	OPHTHALMIC ANTIBIOTICS
	OTIC ANTIBIOTICS
	SYSTEMIC ACNE AGENT, VITAMIN A DERIVATIVES
	ANTIPSORIATICS AGENTS
8/6/2003	ANTIVIRAL (INFLUENZA AGENTS)
	ANTIVIRAL (ANTI-HERPTIC AGENTS)
	TOPICAL ANTIFUNGALS (include nystatin, mycostatin, griseof
	VAGINAL ANTIMICROBIALS
	TOPICAL ESTROGEN AGENTS
	ANTI-ULCER-H.PYLORI AGENTS
Aug-2003	Begin Re-Review

Effective through 9/30/2003

INDIANA MEDICAID PREFFERRED DRUG LIST

ACE INHIBITORS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Captopril 12.5mg tabs	(12 years and under)	9/17/2002
Captopril 25mg tabs	(12 years and under)	9/17/2002
Captopril 50mg tabs	(12 years and under)	9/17/2002
Captopril 100mg tabs	(12 years and under)	9/17/2002
Enalapril	(all strengths)	9/17/2002
Lisinopril	(all strengths)	9/17/2002
Lotensin 10mg tabs		9/17/2002
Lotensin 20mg tabs		9/17/2002
Lotensin 40mg tabs		9/17/2002
Mavik 1mg tabs		9/17/2002
Mavik 2mg tabs		9/17/2002
Mavik 4mg tabs		9/17/2002
Monopril 10mg tabs		9/17/2002
Monopril 20mg tabs		9/17/2002
Monopril 40mg tabs		9/17/2002
Non Preferred Drugs		
Accupril 5mg tabs		9/17/2002
Accupril 10mg tabs		9/17/2002
Accupril 20mg tabs		9/17/2002
Accupril 40mg tabs		9/17/2002
Aceon 2mg tabs		9/17/2002
Aceon 4mg tabs		9/17/2002
Aceon 8mg tabs		9/17/2002
Altace 1.25mg caps		9/17/2002
Altace 2.5mg caps		9/17/2002
Altace 5mg caps		9/17/2002
Altace 10mg caps		9/17/2002
Capozide 12.5mg tabs*	(over 12 years old)	9/17/2002
Captopril 25mg tabs*	(over 12 years old)	9/17/2002
Captopril 50mg tabs*	(over 12 years old)	9/17/2002
Captopril 100mg tabs*	(over 12 years old)	9/17/2002
Prinivil*/Zestril*		9/17/2002
Univasc 7.5mg tabs		9/17/2002
Univasc 15mg tabs		9/17/2002
Vasotec*		9/17/2002

ACE INHIBITORS with CCB

Preferred Drugs		
Lotrel	(limit 30 tabs/month)	12/10/2002
Non-Preferred Drugs		
Lexxel		12/10/2002
Tarka		12/10/2002

ACE INHIBITORS with DIURETICS

Preferred Drugs		
Captopril/HCTZ		12/10/2002
Enalapril/HCTZ		12/10/2002
Lisinopril/HCTZ		12/10/2002
Lotensin HCT		12/10/2002
Monopril HCT		12/10/2002
Non-Preferred Drugs		
Accuretic		12/10/2002
Capozide*		12/10/2002
Prinzide*/Zestoretic*		12/10/2002
Uniretic		12/10/2002
Vaseretic*		12/10/2002

ALPHA ADRENERGIC BLOCKERS

Preferred Drugs		
Doxazosin	(all strengths)	10/9/2002
Prazosin	(all strengths)	10/9/2002
Terazosin	(all strengths)	10/9/2002
Non-Preferred Drugs		
Cardura tabs*	(all strengths)	10/9/2002
Hytrin caps*	(all strengths)	10/9/2002
Minipress caps*	(all strengths)	10/9/2002

ARBs with DIURETICS

Preferred Drugs		
Hyzaar		12/10/2002
Micardis HCT		12/10/2002
Non-Preferred Drugs		
Atacand HCT		12/10/2002
Avalide		12/10/2002
Diovan HCT		12/10/2002

BETA ADRENERGIC BLOCKERS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Acebutolol	(all strengths)	10/9/2002
Atenolol	(all strengths)	10/9/2002
Betaxolol 10mg tabs		10/9/2002
Betaxolol 20mg tabs		10/9/2002
Bisoprolol	(all strengths)	10/9/2002
Inderal 10mg tabs**		10/9/2002
Inderal 20mg tabs**		10/9/2002
Inderal 40mg tabs**		10/9/2002
Inderal 60mg tabs**		10/9/2002
Inderal 80mg tabs**		10/9/2002
Inderal-LA	(all LA strengths)	10/9/2002
Labetalol	(all strengths/formulations)	10/9/2002
Lopressor 50mg tabs**		10/9/2002
Lopressor 100mg tabs**		10/9/2002
Metoprolol	(all strengths/formulations)	10/9/2002
Nadolol	(all strengths)	10/9/2002
Pindolol	(all strengths)	10/9/2002
Propranolol	(all strengths/formulations)	10/9/2002
Sotalol 80mg tabs		10/9/2002
Sotalol 120mg tabs		10/9/2002
Sotalol 160mg tabs		10/9/2002
Sotalol 240mg tabs		10/9/2002
Tenormin 25mg tabs**		10/9/2002
Tenormin 50mg tabs**		10/9/2002
Tenormin 100mg tabs**		10/9/2002
Timolol 5mg tabs		10/9/2002
Timolol 10mg tabs		10/9/2002
Timolol 20mg tabs		10/9/2002
Toprol XL 25mg tabs		10/9/2002
Toprol XL 50mg tabs		10/9/2002
Toprol XL 100mg tabs		10/9/2002
Toprol XL 200mg tabs		10/9/2002
Non-Preferred Drugs		
Betapace 80mg tabs*		10/9/2002
Betapace 120mg tabs*		10/9/2002
Betapace 160mg tabs*		10/9/2002
Betapace 240mg tabs*		10/9/2002
Betapace AF 80mg tabs		10/9/2002
Betapace AF 120mg tabs		10/9/2002
Betapace AF 160mg tabs		10/9/2002
Blocadren 5mg tabs*		10/9/2002
Blocadren 10mg tabs*		10/9/2002
Blocadren 20mg tabs*		10/9/2002
Cartrol 2.5mg tabs		10/9/2002
Cartrol 5mg tabs		10/9/2002
Coreg 3.125mg tabs	(new treatment only)	10/9/2002
Coreg 6.25mg tabs	(new treatment only)	10/9/2002
Coreg 12.5mg tabs	(new treatment only)	10/9/2002
Coreg 25mg tabs	(new treatment only)	10/9/2002
Corgard 20mg tabs*		10/9/2002
Corgard 40mg tabs*		10/9/2002
Corgard 80mg tabs*		10/9/2002
Corgard 120mg tabs*		10/9/2002
Corgard 160mg tabs*		10/9/2002
Kerlone 10mg tabs		10/9/2002
Kerlone 20mg tabs		10/9/2002
Levatol 20mg tabs		10/9/2002
Normodyne 100mg tabs*		10/9/2002
Normodyne 200mg tabs*		10/9/2002
Normodyne 300mg tabs*		10/9/2002
Sectral 200mg caps*		10/9/2002
Sectral 400mg caps*		10/9/2002
Trandate 100mg tabs*		10/9/2002
Trandate 200mg tabs*		10/9/2002
Trandate 300mg tabs*		10/9/2002
Visken 10mg tabs*		10/9/2002
Visken 5mg tabs*		10/9/2002
Zebeta 5mg tabs*		10/9/2002
Zebeta 10mg tabs*		10/9/2002

BPH

Preferred Drugs		
Flomax		12/10/2002
Proscar		12/10/2002
Non-Preferred Drugs		
None		12/10/2002

CALCIUM CHANNEL BLOCKERS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Adalat CC 90mg tabs		10/9/2002
Calan**	(all strengths)	10/9/2002
Covera-HS 180mg tabs		10/9/2002
Covera-HS 240mg tabs		10/9/2002
Diltiazem	(all forms/strengths)	10/9/2002
Dynacirc	(all strengths)	10/9/2002
Dynacirc CR 5mg tabs		10/9/2002
Dynacirc CR 10mg tabs		10/9/2002
Isoptin**	(all strengths)	10/9/2002
Nicardipine	(all strengths)	10/9/2002
Nifedipine long-acting	(all strengths)	10/9/2002
Nimotop 30mg caps		10/9/2002
Norvasc	(all strengths)	10/9/2002
Plendil	(all strengths)	10/9/2002
Sular	(all strengths)	10/9/2002
Tiazac	(all strengths)	10/9/2002
Verapamil	(all strengths)	10/9/2002
Verelan PM 100mg caps		10/9/2002
Verelan PM 200mg caps		10/9/2002
Verelan PM 300mg caps		10/9/2002
Verelan 120mg caps**		10/9/2002
Verelan 180mg caps**		10/9/2002
Verelan 240mg caps**		10/9/2002
Verelan 360mg caps**		10/9/2002
Non-Preferred Drugs		
Adalat 10mg caps		10/9/2002
Adalat 20mg caps		10/9/2002
Adalat CC 30mg tabs*		10/9/2002
Adalat CC 60mg tabs*		10/9/2002
Cardene 20mg caps		10/9/2002
Cardene 30mg caps		10/9/2002
Cardene SR 30mg caps		10/9/2002
Cardene SR 45mg caps		10/9/2002
Cardene SR 60mg caps		10/9/2002
Cardizem*	(all strengths)	10/9/2002
Dilacor XR 120mg caps		10/9/2002
Dilacor XR 180mg caps		10/9/2002
Dilacor XR 240mg caps		10/9/2002
Nifedipine(short acting)	(all strengths)	10/9/2002
Procardia 10mg caps		10/9/2002
Procardia 20mg caps		10/9/2002
Procardia XL 30mg tabs*		10/9/2002
Procardia XL 60mg tabs*		10/9/2002
Procardia XL 90mg tabs		10/9/2002
Visecor 300mg tabs		10/9/2002
Visecor 360mg tabs		10/9/2002

HMG CoA REDUCTASE INHIBITORS

Preferred Drugs		
Lescol		12/10/2002
Lescol XL		12/10/2002
Lipitor		12/10/2002
Lovastatin		12/10/2002
Pravachol	HIV Patients only	12/10/2002
Zocor		12/10/2002
Non-Preferred Drugs		
Advicor		12/10/2002
Altocor		12/10/2002
Mevacor*		12/10/2002

INHALED CORTICOSTEROIDS

Preferred Drugs		
Advair		12/10/2002
Asmacort		12/10/2002
Flovent 44mcg Inhaler		12/10/2002
Flovent 110mcg Inhaler		12/10/2002
Pulmicort Respules	(age 8 and under)	12/10/2002
Pulmicort Turbohaler	(age>8,limit 1/mo)	12/10/2002
Qvar		12/10/2002
Non-Preferred Drugs		
AeroBID & AeroBID M		12/10/2002
Beclovent		12/10/2002
Flovent 220mcg Inhaler		12/10/2002
Flovent Rotadisk		12/10/2002
Vanceril & Vanceril DS		12/10/2002

Effective through 9/30/2003

Page 2

INDIANA MEDICAID PREFERRED DRUG LIST

LEUKOTRIENE INHIBITORS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Accolate		12/10/2002
Singulair		12/10/2002
Non-Preferred Drugs		
Zyflo		12/10/2002

LONG-ACTING BETA AGONISTS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Serevent		12/10/2002
Non-Preferred Drugs		
Foradil		12/10/2002

LOOP DIURETICS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Bumetanide	(all strength/formulations)	10/9/2002
Furosemide	(all strength/formulations)	10/9/2002
Torsemide	(all strength/formulations)	10/9/2002
Non-Preferred Drugs		
Bumex*	(all strengths)	10/9/2002
Demadex*	(all strengths)	10/9/2002
Edecrin 25mg tabs		10/9/2002
Edecrin 50mg tabs		10/9/2002
Lasix*	(all strengths)	10/9/2002

NASAL CORTICOSTEROIDS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Astelin		12/10/2002
Beconase		12/10/2002
Beconase AQ		12/10/2002
Flonase		12/10/2002
Nasacort		12/10/2002
Nasacort AQ		12/10/2002
Nasalide		12/10/2002
Nasarel		12/10/2002
Nasonex		12/10/2002
Rhinocort		12/10/2002
Rhinocort AQ		12/10/2002
Tri-Nasal		12/10/2002
Vancenase		12/10/2002
Vancenase AQ		12/10/2002
Vancenase AQ DS		12/10/2002
Non-Preferred Drugs		
None		12/10/2002

NON-SEDATING ANTIHISTAMINES

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Allegra 180mg tabs	(1 tablet per day)	8/21/2002
Allegra 30mg tabs	(2 tablets per day)	8/21/2002
Allegra 60mg tabs/caps	(2 tablets/capsules/day)	8/21/2002
Zyrtec 1mg/ml syrup	(10 ml/day)	8/21/2002
Non-Preferred Drugs		
Allegra-D tabs		8/21/2002
Clarinex 5mg tabs		8/21/2002
Claritin 10mg red-tabs		8/21/2002
Claritin 10mg tabs		8/21/2002
Claritin 10mg/10ml syrup		8/21/2002
Claritin-D 12 hour tabs		8/21/2002
Claritin-D 24 hour tabs		8/21/2002
Zyrtec 5mg tabs		8/21/2002
Zyrtec 10mg tabs		8/21/2002
Zyrtec-D 12 hour tabs		8/21/2002

PLATELET AGGREGATION INHIBITORS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Plavix 75mg tabs		10/9/2002
Ptelal 100mg tabs		10/9/2002
Ptelal 50mg tabs		10/9/2002
Non-Preferred Drugs		
Aggrenox		10/9/2002
Ticlid 250mg tabs		10/9/2002
Ticlopidine 250mg tabs		10/9/2002

PROTON PUMP INHIBITORS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Omeprazole	(all strength/formulations)	12/13/2002
Prilosec 20mg caps	(12 years and under)	9/17/2002
Protonix 40mg tabs	(1 tablet per day)	9/17/2002
Non-Preferred Drugs		
Aciphex 20mg tabs		9/17/2002
Nexium	(all strengths)	9/17/2002
Prevacid 15mg caps		9/17/2002
Prevacid 30mg caps		9/17/2002
Prevacid suspension	(all strengths)	9/17/2002
Prilosec (except 20 mg)*		9/17/2002
Prilosec 20mg caps*	(over 12 years old)	9/17/2002
Protonix 20mg tabs		9/17/2002
Protonix IV 40mg vial		9/17/2002

SHORT-ACTING BETA AGONISTS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Albuterol	all strengths/formulations	12/10/2002
limit 3 canisters/mo. ages < 19; 2 canisters/mo. ages 19 and up		
Non-Preferred Drugs		
Alupent		12/10/2002
Brethine		12/10/2002
MaxAir		12/10/2002
Proventa		12/10/2002
Proventil*		12/10/2002
Proventil HFA		12/10/2002
Terbutaline		12/10/2002
Ventolin*		12/10/2002
Xopenex		12/10/2002

THIAZOLIDENEDIONES

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Actos 15mg	(limit 90 tablets/month)	12/10/2002
Avandia 4mg	(limit 30 tablets/month)	12/10/2002
Avandia 8 mg	(limit 30 tablets/month)	12/10/2002
Non-Preferred Drugs		
Actos 30mg		12/10/2002
Actos 45mg		12/10/2002
Avandia 2mg		12/10/2002

TRIPTANS

DRUG CLASS	LIMITS	DATE
Axert	(1 box-6 tablets/month)	12/10/2002
Imitrex 5mg nasal spray	(1 box-6 inhalers, 6mls/mo)	12/10/2002
Imitrex 20mg nasal spray	(1 box-6 inhalers, 6mls/mo)	12/10/2002
Imitrex 25mg tabs	(11 box-9 tablets/month)	12/10/2002
Imitrex 50mg tabs	(1 box-9 tablets/month)	12/10/2002
Imitrex 100mg tabs	(1 box-9 tablets/month)	12/10/2002
Imitrex stat dose refill	(1 box-2 injections/month)	12/10/2002
Imitrex vial	(2 vials-2 injections/month)	12/10/2002
Non-Preferred Drugs		
Amerge		12/10/2002
Frova		12/10/2002
Maxalt		12/10/2002
Maxalt MLT		12/10/2002
Zomig		12/10/2002
Zomig ZMT		12/10/2002

MACROLIDES

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Biaxin	Biaxin XL PAC 1 per 25 days	1/7/2003
Dynabac	D-5PAC 1 per 25 days	1/7/2003
Erythromycin*	Generic doses & formulations	1/7/2003
Zithromax	Z-PAK/TRI-PAK 1 per 25 days	1/7/2003

FLUOROQUINOLONES*

*Beginning on January of 2003, all fluoroquinolones will be limited to a 14-day supply.

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Avelox	ABC PAC one per 25 days	1/7/2003
Cipro		1/7/2003
Floxin		1/7/2003
Levaquin		1/7/2003
Maxaquin		1/7/2003
Noroxin		1/7/2003
Tequin	TEQ-PAC one per 25 days	1/7/2003
Zagam		1/7/2003

CEPHALOSPORINS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
All generic first and second generation cephalosporins		1/7/2003
Omnicef		1/7/2003
Non-Preferred Drugs		
Ceclor Brand*		1/7/2003
Cedax		1/7/2003
Ceftin Brand*		1/7/2003
Cefzil		1/7/2003
Lorabid		1/7/2003
Spectracef		1/7/2003
Vantin		1/7/2003

ANTIFUNGALS

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Diflucan tabs 100 &200mg		1/7/2003
Diflucan 150mg	2 tabs every 14 days	1/7/2003
Grifulvin V		8/6/2003
Griseofulvin tabs	generic products	8/6/2003
Ketoconazole	generic products	1/7/2003
Non-Preferred Drugs		
Fulvicin		8/6/2003
Grisactin		8/6/2003
Gris-Peg		8/6/2003
Lamisil		1/7/2003
Mycelex Brand*		1/7/2003
Sporanox		1/7/2003
Vfend		1/7/2003

ARBs

ARBs are subject to the following Step Edit
Patients must have failed an ACEI within the previous year.

DRUG CLASS	LIMITS	DATE
Preferred Drugs		
Cozaar	1 tablet per day	1/7/2003
Micardis	1 tablet per day	1/7/2003
Non-Preferred Drugs		
Atacand		1/7/2003
Avapro		1/7/2003
Benicar		1/7/2003
Diovan		1/7/2003
Teveten		1/7/2003

*Note: In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and "cross indicated" drugs are considered as being on the PDL. Also included on the PDL are drugs that are (1.) classified in a central nervous system drug category or classification (according to Drug Facts and Comparisons) that is created after March 12, 2002, and (2) prescribed for the treatment of a mental illness (as defined in the most recent publication of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders).

* Brand Name medications with a generic available are non-PDL. When a brand name drug having generic equivalents is included in the "Non-Preferred Drug List" listing, please note that the generic equivalents for the brand name drug are considered as being ON PDL and therefore do not require prior approval.)

Prior authorization for Brand Medically Necessary is not required for the drugs specifically exempted by the DUR Board from a prior authorization for Brand Medically Necessary requirement (those drugs being what are typically referred to as "narrow therapeutic index" drugs).

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INDIANA MEDICAID PREFERRED DRUG LIST

BILE ACID SEQ.

Preferred Drugs		
Cholestyramine	(multi-dose powder containers only)	5/14/2003
Locholest powder	(multi-dose powder containers only)	5/14/2003
Prevalite powder	(multi-dose powder containers only)	5/14/2003
Colestid	(multi-dose flavored granules containers)	5/14/2003
Non-Preferred Drugs		
Questran*	(all formulations)	5/14/2003
Cholestyramine	(packets)	5/14/2003
Prevalite	(packets)	5/14/2003
Colestid	(packets and tablets)	5/14/2003
Welchol 625mg		5/14/2003

NARCOTIC AGENTS

Preferred Drugs		
Acetaminophen/ Codeine #2	(limited to 3 grams of acetaminophen/day)	5/14/2003
Acetaminophen/ Codeine #3	(limited to 3 grams of acetaminophen/day)	5/14/2003
Acetaminophen/ Codeine #4	(limited to 3 grams of acetaminophen/day)	5/14/2003
Aspirin with codeine		5/14/2003
Butorphanenol nasal spray	(limited to 1 vial/25 days, 2 vials require prior authorization)	5/14/2003
Duragesic 100mcg patch	(limited to 10 patches any strength/month)	5/14/2003
Duragesic 25mcg patch	(limited to 10 patches any strength/month)	5/14/2003
Duragesic 50mcg patch	(limited to 10 patches any strength/month)	5/14/2003
Duragesic 75mcg patch	(limited to 10 patches any strength/month)	5/14/2003
Hydrocodone	(all formulations)	5/14/2003
Hydromorphone		5/14/2003
Oxycodone	(all combinations)	5/14/2003
Oxycontin 10mg	(limited to 120 tabs/25 days)	5/14/2003
Oxycontin 20mg	(limited to 120 tabs/25 days)	5/14/2003
Oxycontin 40mg	(limited to 120 tabs/25 days)	5/14/2003
Oxycontin 80mg	(limited to 60 tabs/25 days)	5/14/2003
Pentazocine lactate	(all formulations)	5/14/2003
Propoxyphene	(all formulations)	5/14/2003
Tramadol HCl	(limited to 4 grams/day)	5/14/2003
Non-Preferred Drugs		
Actiq		5/14/2003
Darvocet N 100*		5/14/2003
Darvon Cmpd. 65*		5/14/2003
Darvon N 100		5/14/2003
Darvon*		5/14/2003
Dilaudid*		5/14/2003
Empirin*		5/14/2003
Kadian		5/14/2003
Lorcet*		5/14/2003
Maxidone		5/14/2003
Norco*		5/14/2003
Percocet*		5/14/2003
Percodan*		5/14/2003
Stadol Nasal Spray*	(all formulations)	5/14/2003
Talwin*		5/14/2003
Tylenol # 2*		5/14/2003
Tylenol # 3*		5/14/2003
Tylenol # 4*		5/14/2003
Ultracet		7/21/2003
Ultram*		5/14/2003
Vicoprofen		5/14/2003
Vicodin*		5/14/2003
Zydone		5/14/2003

FIBRIC ACIDS

Preferred Drugs		
Lofibra 200mg tabs		5/14/2003
TriCor 160mg tabs		5/14/2003
TriCor 200mg tabs		5/14/2003
Non-Preferred Drugs		
Lopid 600mg		5/14/2003
Tricor 54mg	(current tx. Grandfathered)	5/14/2003
Tricor 67mg	(current tx. Grandfathered)	5/14/2003

URINARY TRACT ANTISPASMODIC

Preferred Drugs		
Oxybutynin	step edit for long acting, must fail immediate release	5/14/2003
Non-Preferred Drugs		
Detrol LA	(current tx. Grandfathered)	5/14/2003
Detrol*		5/14/2003
Ditropan XL	(current tx. Grandfathered)	5/14/2003
Ditropan*		5/14/2003
Urispas		5/14/2003

ANTIDIABETIC AGENTS

Amaryl		5/14/2003
Avandamet	Step edit, failed one of the agents in combo; current tx.grandfathered.	5/14/2003
Glipizide		5/14/2003
Glucotrol XL		5/14/2003
Glucovance	Step edit, failed one of the agents in combo; current tx.grandfathered	5/14/2003
Glyburide	(all strengths)	5/14/2003
Glyset		5/14/2003
Metaglip	Step edit, failed one of the agents in combo; current tx.grandfathered	5/14/2003
Metformin		5/14/2003
Prandin		5/14/2003
Precose		5/14/2003
Starlix		5/14/2003
Non-Preferred Drugs		
Acetohexamide		5/14/2003
Chlorpropamide		5/14/2003
Diabeta*		5/14/2003
Diabinese		5/14/2003
Dymelor		5/14/2003
Glucophage XR		5/14/2003
Glucophage*		5/14/2003
Glucotrol*		5/14/2003
Micronase*		5/14/2003
Orinase		5/14/2003
Tolazamide		5/14/2003
Tolbutamide		5/14/2003
Tolinase		5/14/2003

SKELETAL MUSCLE RELAXANTS

Preferred Drugs		
Baclofen		5/14/2003
Chlorzoxazone		5/14/2003
Cyclobenzaprine HCl		5/14/2003
Dantrolene Sodium		5/14/2003
Methocarbamol		5/14/2003
Orphenadrine Citrate		5/14/2003
Tizanidine HCl		5/14/2003
Non-Preferred Drugs		
Carisoprodol	(all formulations)	5/14/2003
Dantrium*		5/14/2003
Flexeril*		5/14/2003
Lorzone*		5/14/2003
Norflex*		5/14/2003
Norgesic Forte*		5/14/2003
Parafles*		5/14/2003
Parafon Forte*		5/14/2003
Robaxin*		5/14/2003
Skelaxin		5/14/2003
Soma	(all formulations)	5/14/2003
Zanaflex*		5/14/2003

ANTIEMETIC/ANTIVERTIGO

Preferred Drugs		
Kytril	10 tabs per prescription	2/26/2003
Zofran	10 tabs per prescription	2/26/2003
Zofran Oral solution	1 bottle per prescription	2/26/2003
Non-Preferred Drugs		
Anzemet	10 tabs per prescription	2/26/2003

HEPARIN/RELATED PRODUCTS

Preferred Drugs		
Heparin	all generics; all formulations	2/26/2003
Fragmin	Prefilled syringes	2/26/2003
Lovenox	Prefilled syringes	2/26/2003
Non-Preferred Drugs		
Arixtra		2/26/2003
Fragmin	formulations other than prefilled syringes	2/26/2003
Lovenox		2/26/2003
Innohep		2/26/2003

SERMS/BONE RESORP.SUPPRESSION

Preferred Drugs		
Actonel	QD and weekly	2/26/2003
Etidronate disodium	generic formulation	2/26/2003
Evista		2/26/2003
Fosamax	weekly only	2/26/2003
Non-Preferred Drugs		
Didronel		2/26/2003
Fosamax QD*		2/26/2003
Miacalcin		2/26/2003
Skelid		2/26/2003
Forteo		7/21/2003

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INDIANA MEDICAID PREFERRED DRUG LIST

OPHTH. MAST CELL STABILIZERS

Preferred Drugs		
Alamast		7/21/2003
Cromolyn		7/21/2003
Lirowtatin		7/21/2003
Optivar*	step edit	7/21/2003
Patanol*	step edit	7/21/2003
Zaditor*	step edit	7/21/2003
*must have failed 1 of the above in last 12 months-no grandfathering		
Non-Preferred Drugs		
Alocril		7/21/2003
Alomide		7/21/2003
Crolom		7/21/2003
Emadine		7/21/2003
Opticrom		7/21/2003

OPHTH. ANTIBIOTCS

All generic products		7/21/2003
Bacitracin		7/21/2003
Chloramphenicol		7/21/2003
Erythromycin		7/21/2003
Gentamycin		7/21/2003
Gentamicin/Prednisolone		7/21/2003
Kalamycin		7/21/2003
N/PB*		7/21/2003
N/PG*		7/21/2003
N/P/Prednisolone*		7/21/2003
N/P/Dexamethasone*		7/21/2003
Ocuflox		7/21/2003
P/B*		7/21/2003
P/Trimethoprim*		7/21/2003
terramycin/P*		7/21/2003
tobramycin		7/21/2003
*N=Neomycin; P=Polymyxin B; G=Gramicidin; B=Bacitracin		
Non-Preferred Drugs		
Any brand with a generic		7/21/2003
AK-Tracin		7/21/2003
Chloroptic		7/21/2003
Ciloxin		7/21/2003
Cortisporin		7/21/2003
Ilotycin		7/21/2003
Garamycin		7/21/2003
Maxitrol		7/21/2003
Natacyn		7/21/2003
Neo-Decadron		7/21/2003
Neo-Dexameth		7/21/2003
Neosporin		7/21/2003
Poly-Pred		7/21/2003
Polysporin		7/21/2003
Polytrim		7/21/2003
Pred-G		7/21/2003
Quinin		7/21/2003
Tobradex		7/21/2003
Tobrex		7/21/2003

ANTIVIRAL (INFLUENZA) AGENTS

Preferred Drugs		
Amantidine	generic products	8/6/2003
Rimantidine	generic products	8/6/2003
Non-Preferred Drugs		
Flumadine		8/6/2003
Relenza		8/6/2003
Symmetrel		8/6/2003
Tamiflu		8/6/2003

ANTIULCER/H.PYLORI AGENTS

Preferred Drugs		
None		8/6/2003
Non-Preferred Drugs		
Helidac		8/6/2003
Prevpac		8/6/2003

MIOTICS

Preferred Drugs		
Azopt		7/21/2003
Betaxol		7/21/2003
Carteolol		7/21/2003
Cosopt		7/21/2003
Epinephrine		7/21/2003
Iopidine		7/21/2003
Isopto-Carbachol		7/21/2003
Levobunolol		7/21/2003
Lumigan		7/21/2003
Metipranolol		7/21/2003
Physostigmine		7/21/2003
Pilocarpine		7/21/2003
Timolol		7/21/2003
Travatan		7/21/2003
Trusopt		7/21/2003
Xalatan		7/21/2003
Non-Preferred Drugs		
Betagan		7/21/2003
Betimol		7/21/2003
Betoptic-S		7/21/2003
E-Pilo-X		7/21/2003
Humorsol		7/21/2003
Isopto-Carpine		7/21/2003
Isopto-Eserine		7/21/2003
Ocupress		7/21/2003
Opti-Pranolol		7/21/2003
Phospholine Iodide		7/21/2003
Pilocar		7/21/2003
Pilopine-HS		7/21/2003
Rescula		7/21/2003
Timoptic		7/21/2003
Timoptic XE		7/21/2003
Alphagan P	grandfathered for 1 year prior to	8/6/2003

SMOKING DETERRENT AGENTS

Preferred Drugs		
Therapy limited to 12 weeks every 365 days per statute		
Commit Lozenge		7/21/2003
Nicotine Gum		7/21/2003
Nicotine Patch		7/21/2003
Nicotrol Inhaler		7/21/2003
Nicotrol NS		7/21/2003
Non-Preferred Drugs		
Habitrol		7/21/2003
Nicoderm		7/21/2003
Nicorette		7/21/2003
Nicorette DS		7/21/2003
Nicotrol		7/21/2003

ANTIVIRAL (ANTI-HERPETIC) AGENTS

Preferred Drugs		
Acyclovir	generic products	8/6/2003
Valtrex		8/6/2003
Zovirax 200 mg caps		8/6/2003
Zovirax 400 mg tabs		8/6/2003
Zovirax Suspension		8/6/2003
Non-Preferred Drugs		
Famvir		8/6/2003
Zovirax 800mg tabs		8/6/2003
Zovirax 800mg tabs		8/6/2003

TOPICAL ESTROGEN AGENTS

Preferred Drugs		
Estrace Vaginal Cream		8/6/2003
Estring		8/6/2003
Ogen		8/6/2003
Ortho-Dienestrol		8/6/2003
Premarin Vaginal Cream		8/6/2003
Vagifem		8/6/2003
Non-Preferred Drugs		
none		8/6/2003

OTIC ANTIBIOTICS

Preferred Drugs		
All generic products		7/21/2003
Chloramphenicol		7/21/2003
Floxin		7/21/2003
Neomycin/Polymyxin/B/HC		7/21/2003
Polymyxin B/HC		7/21/2003
Cipro HC	age 12 and under	7/21/2003
Non-Preferred Drugs		
Chloromycetin		7/21/2003
Coly-Mycin S		7/21/2003
Cortisporin		7/21/2003
Octicair		7/21/2003
Otobiotic		7/21/2003
Otosporin		7/21/2003
Pediotic		7/21/2003
Cipro HC	over 12 years old	7/21/2003

VITAMIN A DERIVATIVES

Preferred Drugs		
Approved for patients < or = 25 years of age		
All generic Tretinoin	all formulations	7/21/2003
Accutane	brand and generic	7/21/2003
Differin	step edit*	7/21/2003
*step edit requires one year previous use of tretinoin		
Non-Preferred Drugs		
Avita		7/21/2003
Retin-A	all formulations	7/21/2003

ANTIPSORIATICS

Preferred Drugs		
Dovonex		7/21/2003
Orthocreme HP		7/21/2003
Ossorelen-Ultra		7/21/2003
Psoriatic		7/21/2003
Soriatan		7/21/2003
Tazorac		7/21/2003
Non-Preferred Drugs		
None		7/21/2003

LEUKOCYTE (WBC) STIMULENTS

Preferred Drugs		
Leukine	vials only	7/21/2003
Neupogen	vials only	7/21/2003
Non-Preferred Drugs		
Neulasta	prefilled syringes	7/21/2003
Neupogen	prefilled syringes	7/21/2003

HEMATINICS

Preferred Drugs		
Aranesp	all forms/strengths	7/21/2003
Epogen	all forms/strengths	7/21/2003
Procrit	all forms/strengths	7/21/2003
Non-Preferred Drugs		
None		7/21/2003

VAGINAL ANTIMICROBIALS

Preferred Drugs		
Clotrimazol		8/6/2003
Miconazole		8/6/2003
Tioconazole		8/6/2003
Non-Preferred Drugs		
Cleocin Vaginal	cleam/ovule	8/6/2003
Gynazole 1		8/6/2003
Gyne-Lotrimin		8/6/2003
Metrogel Vaginal		8/6/2003
Monistat		8/6/2003
Mycelex		8/6/2003
Terazole		8/6/2003
Vagistat-1		8/6/2003

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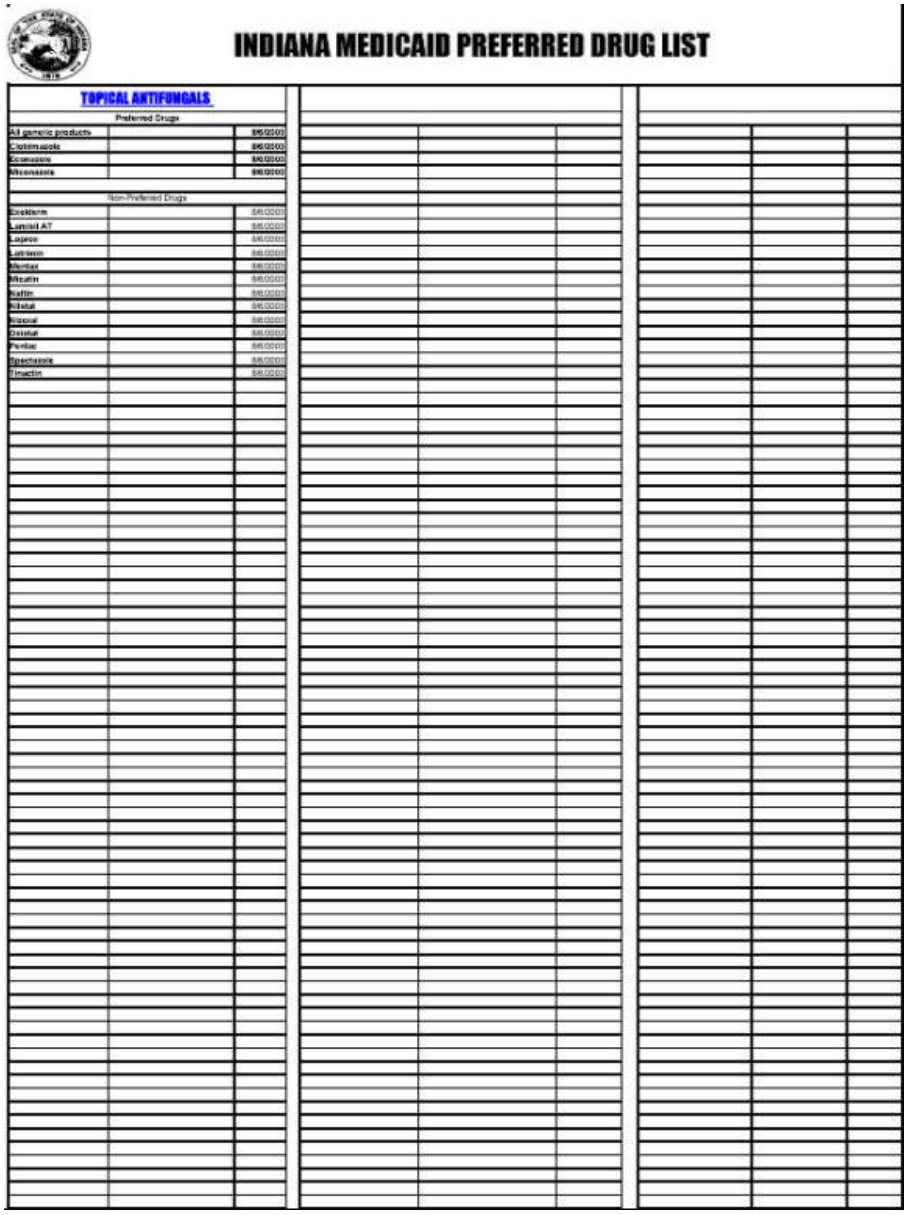

INDIANA MEDICAID PREFERRED DRUG LIST

TOPICAL ANTIFUNGALS

Preferred Drugs		
All generic products		[illegible]
Clotrimazole		[illegible]
Econazole		[illegible]
Miconazole		[illegible]
Non-Preferred Drugs		
Exoderm		[illegible]
Lamisil AT		[illegible]
Loprox		[illegible]
Lotrimin		[illegible]
Mentax		[illegible]
Micatin		[illegible]
Nafitin		[illegible]
Nizoral		[illegible]
Oxistat		[illegible]
Penlac		[illegible]
Spectazole		[illegible]
Tinactin		[illegible]

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ATTACHMENT 5

POLICIES ON USE OF THERAPEUTICALLY EQUIVALENT GENERIC DRUGS

Indiana statute mandates substitution of a generically equivalent drug for a prescribed brand name drug, unless the prescribing practitioner properly indicates “Brand Medically Necessary” on the prescription and obtains prior authorization.

For your reference, copies of the Indiana generic substitution law, Indiana Administrative Code and Indiana Provider Bulletins on generic substitution are provided.

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ATTACHMENT 5.1 GENERIC SUBSTITUTION LAW

Indiana Code 16-42-22 Drugs: Generic Drugs*

*Presented in its entirety for reference.

16-42-22-1 "Brand name" defined

Sec. 1. As used in this chapter, "brand name" means the proprietary or trade name selected by the drug manufacturer and placed upon a drug or the drug's container, label, or wrappings at the time of packaging. *As added by P.L.2-1993, SE .25.*

16-42-22-3 "Customer" defined

Sec. 3. As used in this chapter, "customer" means the individual for whom a prescription is written or the individual's representative. *As added by P>L>2-1993, SEC.25.*

16-42-22-4 "Generically equivalent drug product" defined

Sec. 4. (a) As used in this chapter, "generically equivalent drug product" means a drug product"

- that contains an identical quantity of active ingredients in the identical dosage forms (but not necessarily containing the same inactive ingredients) that meet the identical physical and chemical standards in The United States Pharmacopoeia (USP) described in IC 16-4-19-2, or its supplements, as the prescribed brand name drug; and
- if applicable, for which the manufacturer or distributor holds either an approved new drug application or an approved abbreviated new drug application unless other approval by law or of the federal Food and Drug Administration is required.
    - A drug does not constitute a generically equivalent drug product if it is listed by the federal Food and Drug Administration on July 1, 1987, as having actual or potential bioequivalence problems.

As added by P.L.2-1993, SEC.25. Amended by P.L. 239-1999, SEC 4.

16-42-22-4.5 "Practitioner" defined

Sec. 4.5. As used in this chapter, "practitioner" means any of the following:

- A licensed physician.
- A dentist licensed to practice dentistry in Indiana
- An optometrist who is licensed to practice optometry in Indiana; and
- An advanced practice nurse licensed and granted the authority to prescribe legend drugs under IC 25-33.

As added by P.L.2-1993, SEC.25. Amended by P.L. 239-1999, Sec.5.

16-42-22-5 "Substitute" defined

Sec. 5. As used in this chapter, "substitute" means to dispense a generically equivalent drug product in place of the brand name drug product prescribed by the practitioner. *As added by P.L.2-1993, SEC.25.*

ATTACHMENT 5.1 -- continued -- Generic Substitution Law

16-42-22-5.5 Authorization to substitute only generically equivalent drug products

Sec. 5.5. Nothing in this chapter authorizes any substitution other than substitution of a generically equivalent drug product. *As added by P.L.2-1993, SEC.6.*

16-42-22-6 Prescription forms

Sec. 6. Each written prescription issued by a practitioner must have two(0) signature lines printed at the bottom of the prescription form, one (1) of which must be signed by the practitioner for the prescription to be valid. Under the blank line on the left side of the form must be printed the words "Dispense as written". Under the blank line of the left side of the form must be printed the words "May substitute". *As added by P.L.2-1993, SEC.25.*

16-42-22-8 Substitution of generically equivalent drug products in non-Medicaid or Medicare prescription

Sec. 8. For substitution to occur for a prescription other than a prescription filled under the traditional Medicaid program (42 U.S.C. 1396 et seq.) or the Medicare program (42 U.S.C 1395 et seq.), the practitioner must sign on the line under which the words "May substitute" appear, and the pharmacist must inform the customer of substitution. This section does not authorize any substitution other than the substitution of a generically equivalent drug product. *As added by P.L.2-1993, SEC.25. Amended by P.L. 239-1999, Sec.7.*

16-42-22-9 Transcription of practitioner's oral instructions to pharmacist

Sec. 9. If the practitioner communicates instructions to the pharmacist orally, the pharmacist shall indicate the instructions in the pharmacist's on handwriting on the written copy of the prescription order. *As added by P.L.2-1993, SEC.25.*

16-42-22-10 "Brand Medically Necessary" Traditional Medical or Medicare prescriptions

Sec. 10. (a) If a prescription is filled under the traditional Medicaid program (42 U.S.C. 1396 et seq.) or the Medicare program (42 U.S.C 1395 et seq.), the pharmacist shall substitute a generically equivalent drug product and inform the customer of the substitution if the substitution would result in a lower price unless:

- the words "Brand Medically Necessary" are written in the practitioner's own writing on the form; or
- the practitioner has indicated that the pharmacist may not substitute a generically equivalent drug product by orally stating that a substitution is not permitted.
    - If a practitioner orally states that a generically equivalent drug product may not be substituted, the practitioner must subsequently forward to the pharmacist a written prescription with the "Brand Medically Necessary" instruction appropriately indicated in the physician's own handwriting.
    - This section does not authorize any substitution other than substitution of a generically equivalent drug product.

As added by P.L.2-1993, SEC.25. Amended by P.L. 239-1999, Sec.8.

ATTACHMENT 5.1 -- continued -- Generic Substitution Law

16-42-22-11 Substitution of generic drugs; identification of brand name drug

Sec. 11. If under this section a pharmacist substitutes a generically equivalent drug product for a brand name drug product prescribed by a practitioner, the prescription container label must identify the brand name drug for which the substitution is made and the generic drug. The identification required under this subsection must take the form of the following statement on the drug container label, with the generic name and the brand name inserted on the blank lines: "_____ Generic for _____". *As added by P.L.2-1993, SEC.25. Amended by P.L. 239-1999, Sec.1.*

16-42-22-12 Identification of manufacturer or distributor of dispensed drug product on prescription

Sec. 12. The pharmacist shall record on the prescription the name of the manufacturer or distributor, or both, of the actual drug product dispensed under this chapter. *As added by P.L.2-1993, SEC.25.*

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ATTACHMENT 5.2 ADMINISTRATIVE CODE 405 IAC 5-24-8

Medicaid rule *405 IAC 5-24-8, Prior Authorization; brand name drugs*

405 IAC 5-24-8 Prior authorization: brand name drugs
Authority: IC 12-8-6-5: IC 12-15-1-10: IC 12-15-21-2

Affected; IC 12-13-7-3: IC 12-15

Sec. 8. a) Prior authorization is required for a brand name drug that:

(1) Is subject to generic substitution under Indiana Law; and
(2) The prescriber has indicated is "brand medically necessary" either orally or in writing on the prescription or drug order.

b) In order for prior authorization to be granted for a brand name drug in such instances, the prescriber must:

(1) Indicate on the prescription or drug order, in the prescriber's own handwriting, the phrase "brand medically necessary"; and
(2) Seek prior authorization by substantiating the medical necessity of the brand name drug as opposed to the less costly generic equivalent.

The prior authorization number assigned to the approved request must be included on the prescription or drug order issued by the prescriber or relayed to the dispensing pharmacist by the prescriber if the prescription is orally transmitted The office may exempt specific drugs or classes of drugs from the prior authorization requirement, based on cost or therapeutic considerations. Prior authorization will be determined in accordance with the provisions of 405 IC 5-3 and 42 U.S.C. 1206r-8(d)(5). (*Office of the Secretary of Family and Social Services; 405 IAC 5-24-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346: filed Sep 27, 1999, 8:55 a.m.: 23IR 319)*

ATTACHMENT 5.3

BULLETINS ISSUED ON GENERIC DRUG POLICIES

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200132 AUGUST 10, 2001

To: All Indiana Health Coverage Programs Physicians, Podiatrists, Dentists, Hospitals, Clinics, Mental Health Providers, and Pharmacies

Subject: Implementation of Prior Authorization Requirement for Brand Medically Necessary Drugs

Note: The information in this bulletin about prior authorization and payment methodology, may vary for practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Policy Change

Effective September 4, 2001, a prescriber's indication of "brand medically necessary" for a prescribed drug will require prior authorization. What this means is that, if a prescriber chooses to specify "brand medically necessary" for a drug, he or she must obtain prior authorization for that brand name drug before the pharmacist can be paid for the brand name drug. This action implements Medicaid rule *405 IAC 5-24-8, Prior Authorization; brand name drugs.*

405 IAC 5-24-8 Prior authorization; brand name drugs

Authority: IC 12-8-6-5: IC 12-15-1-10: IC 12-15-21-2

Affected: IC 12-13-7-3: IC 12-15

Sec. 8. a) Prior authorization is required for a brand name drug that:

(1) Is subject to generic substitution under Indiana Law; and

(2) The prescriber has indicated is "brand medically necessary" either orally or in writing on the prescription or drug order.

(b) In order for prior authorization to be granted for a brand name drug in such instances, the prescriber must:

EDS
P. O. Box 7263
Indianapolis, IN 46207-7263

For more information visit www.indianamedicaid.com

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(1) indicate on the prescription or drug order, in the prescriber's own handwriting, the phrase "brand medically necessary"; and

(2) seek prior authorization by substantiating the medical necessity of the brand name drug as opposed to the less costly generic equivalent.

The prior authorization number assigned to the approved request must be included on the prescription or drug order issued by the prescriber or relayed to the dispensing pharmacist by the prescriber if the prescription is orally transmitted. The office may exempt specific drugs or classes of drugs from the prior authorization requirement, based on cost or therapeutic considerations. Prior authorization will be determined in accordance with the provisions of 405 IC 5-3 and 42 U.S.C. 1396r-8(d)(5). *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346; filed Sep 27, 1999, 8:55 a.m.: 23 IR 319)*

Background Information

The basis for this action is the Food and Drug Administration (FDA)'s position that therapeutically equivalent generic drugs have the same effect in the body as their more expensive brand name counterparts. Therefore, it does not make sense for a tax-funded drug benefit to subsidize the additional cost of brand-name drugs when less expensive, equally effective, generic equivalents can be used. The prior authorization system will be used to allow prescribers to substantiate what constitutes the *medical necessity* of a given brand name drug, when the prescriber chooses to write "brand medically necessary."

The Office of Medicaid Policy and Planning (OMPP) strives to employ prior authorization only in circumstances in which it is clearly warranted to do so. That would include utilization control, cost control, or ensuring quality of care. Over the past two years, Indiana Medicaid reimbursed an estimated extra three million dollars associated with uncontrolled "brand medically necessary." That is three million dollars of additional tax dollars expended for brand name drugs, when therapeutically equivalent, less expensive generics could have been used, simply because "brand medically necessary" overrode otherwise applicable payment levels to the pharmacy. At a time when Medicaid faces unsustainable cost increases, we would be remiss not to implement this reasonable and practical program policy that many other states have already adopted.

Prior Authorization is required only for those drugs that have an established federal upper limit (FUL), maximum allowable cost (MAC), and an "AA" or "AB" rated generic equivalent. The following drugs are excluded from the PA requirement:

- Coumadin®
- Dilantin®

- Lanoxin®
- Premarin®
- Provera®
- Synthroid®
- Tegretol®

How The Process Will Work

Prescribers

In the past, if you wrote a prescription for a substitutable brand name drug for an Indiana Medicaid beneficiary signed on the "Dispense as Written" line, and wrote "brand medically necessary" across the face of the prescription, the pharmacist dispensed the prescribed brand name drug and was paid for it. You were not asked what constituted the medical necessity of the more expensive brand name drug as opposed to generic equivalents. As of September 4, 2001, should you chose to continue to write "brand medically necessary" for such drugs, you will have to document the medical necessity for the brand name drug (as opposed to the generic) through the prior authorization process. A description of that process, and how it meets applicable state and federal requirements for drug prior authorization programs, is found below.

Pharmacists

If after September 4, 2001, you receive a prescription for a substitutable brand name drug that is subject to federal MAC limits and that prescription has "brand medically necessary" specified, you will not be able to get paid for the prescribed brand name drug unless the prescriber has obtained prior authorization. If your request is filed point-of-sale (POS) you will know whether or not prior authorization has been obtained if the claim denied. You may receive a call from a prescriber asking you for the National Drug Code (NDC) of the drug for which he or she is seeking prior authorization; if you can assist the member by providing this information, it will facilitate his or her being able to obtain prior authorization for the drug, and thus assist you in getting paid for what is being prescribed. Bear in mind that, ultimately, it is the prescribing physician's responsibility to initiate and obtain prior authorization for instances in which he or she opts to specify "brand medically necessary."

Description Of The Prior Authorization Process

Prior Authorization for Brand Medically Necessary will be granted in cases where documentation indicates the following.

- *Allergic reaction to excipients in the generic products* – If multiple generics are available, a history of trials of generics from multiple companies must exist.
- *A therapeutic failure to the generic product* – A history of documented previous purchases will be reviewed to determine dosing and compliance issues.
  - Prescribers and pharmacists are encouraged to report experiences with generic drug products that create concerns in product quality, performance, or safety.
  - When a physician or pharmacist observes differences in the pharmacologic effect of a generic drug over its branded drug product in a patient, the health professional is asked to report this concern to the Federal Drug Administration, using the MEDWatch form.
  - If the concern immediately above is the rationale for request of a branded drug, a copy of the MEDWatch form or alternative reporting system submitted to the Federal Drug Administration (FDA) must accompany the prior authorization (PA) request. (One may also call 1-800-FDA-1088 to obtain MedWatch forms.)

Note: Patient requests for brand name drugs will not be approved.

Drugs subject to FUL are listed in the *Indiana Health Coverage Programs (IHCP) Provider Manual* in *Chapter 9*. Additions and deletions are published in IHCP banner page articles and bulletins.

Prior Authorization Process

To obtain approval, the physician must send the following.

- An *Indiana Prior Authorization Request* form (PA Request). A form may be downloaded from www.indianamedicaid.com. The following must be included on or with the form:
  - The 11-digit NDC for the requested drug must be included as the "Service Code Required."
  - The medical necessity for a brand name drug must be documented in the "Clinical Summary." Alternatively, a letter explaining the need for generic substitution exemption may be attached to the prior authorization request.
  - A copy of the MEDWatch form or alternate reporting system submitted to the FDA, if applicable.
- Prior authorization approval generally effective for a one-year supply.

The PA Request and other documentation or letters should be mailed or faxed to the Health Care Excel (HCE) Prior Authorization (PA) Department. PA requests also be called to the HCE Department. However, telephone approvals can only be given for one month and a PA Request will need to be completed as described above and faxed or mailed to the HCE PA Department.

Health Care Excel, Prior Authorization Department
P.O. Box 531520
Indianapolis, IN 46253-1520
Fax Number: (317) 347-4537
Telephone: (317) 347-4511 or (800) 457-4518

Pharmacy Claims Processing

Prescription claims for brand name drugs requiring prior authorization will deny by the Indiana*AIM* claims processing system with a message that prior authorization is required. The pharmacist may then take three possible courses of action.

- Contact the prescriber to get the order changed so a generic drug may be substituted.
- Contact the prescriber and ask he or she submit a PA request.
- Give the prescription back to the patient so he or she can return to the prescribing practitioner.

If the claim is denied and there is an emergency, the prescriber cannot be reached, or the prescription is presented after normal business hours at the HCE PA Department (including week-ends and holidays), a 72-hour supply (*Sec. 1927 (d) 42 USC 1396r-8, "OBRA '90"*) of the drug may be dispensed by the pharmacy at no risk to the pharmacy. Prescriptions meeting these criteria may be dispensed in a sufficient amount to provide medication to the patient until the HCE PA Department can review the PA request.

Claim instructions for emergency situations, situations when the prescribing physician is unavailable, or instances when the HCE PA Department is closed are as follows:

- The pharmacist may use the "06" indicator in the Brand Field Locator on the Drug Claim Form if the prescriber has written "brand medically necessary" in his or her own hand-writing or met other requirements of *IC 16-42-22-10* for "Brand Medically Necessary" Medicaid or Medicare prescriptions.
- The correct number of day's supply (less than or equal to three) would need to be included on the pharmacy claim form.
- If the package size is for greater than three days and cannot be broken, the pharmacist may also dispense the medication at no risk to the pharmacy. However, the claim must be held until PA is obtained for the package size. Prescriptions presented on holiday weekends and filled for more than three days will need to be handled in the same manner.
  - Information may be placed on the PA Request accompanied by the prescription and faxed to the HCE PA Department. A PA number will then be faxed back to the pharmacy.

– Alternatively, the PA Department may be called during business hours, 7:30 a.m. – 6 p.m., Central Standard Time, Monday through Friday.

Prescribers should bear in mind that if they choose to write "brand medically necessary" on their prescriptions and do not initiate the required prior authorization request, it could result in the patient encountering difficulties in obtaining their medication. The mutual goal should be to ensure that patients receive less expensive, therapeutically equivalent generic products whenever feasible and reasonable, while allowing for payment of more expensive brand name products if there are true and valid, documented medical reasons for use of the brand name product.

Further Information

Questions about this bulletin may be directed to the Health Care Excel Medical Policy Department at (317) 347-4500.

Provider Bulletin (BT 200330) on Generic Substitution Policy Changes -- May 22, 2003

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200330 MAY 22, 2003

To: All Pharmacy Providers

Subject: Pharmacy Provider Reviews

Note: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system

Overview

Myers and Stauffer LC, on behalf of the Office of Medicaid Policy and Planning (OMPP), conducted a review of services rendered by pharmacy providers. The purpose of this review was, in part, to gauge provider compliance with applicable statutes, regulations, policies, and procedures. The review included on-site audits of pharmacies, as well as a review of paid pharmacy claims. Based on the results of the review, several issues were identified that have resulted, or will result, in recoupment of Indiana Health Coverage Programs (IHCP) funds.

Note: Claims for IHCP reimbursed services, when such services are subsequently found to have been rendered out of compliance with applicable law and/or policy, are subject to recoupment by the IHCP, and referral of the practice violation to the Indiana Board of Pharmacy, Health Professions Bureau, for follow-up action as deemed necessary and appropriate by that professional regulatory body.

This bulletin reminds providers of policies and procedures that apply to the primary issues identified as a result of the review. It is expected that by bringing these matters to providers' attention, providers will ensure full compliance with applicable law and program parameters. The IHCP expects all pharmacy providers to render all services to IHCP members in full compliance with state and federal practice laws, and with strict observance of, and adherence to, IHCP service documentation requirements. Significant issues revealed as a result of the Myers and Stauffer review are addressed in this bulletin. All pharmacy providers are encouraged to carefully review this information. The IHCP will monitor compliance through future reviews and audits.

Maintenance of Prescription Records

The IHCP requires providers to maintain records for a period of three years from the date of service, and to fully document the services provided to IHCP members according to Indiana Administrative Code (IAC) *405 IAC 1-5-1*. The examination of records maintained by some pharmacies revealed instances where the prescription necessary to support the paid claim was not found. Providers must maintain documentation to support the billing of a claim to the IHCP. All claims billed for prescriptions and subsequent refills for which the provider has not maintained the required documentation are subject to recoupment by the IHCP.

Prescriber License Numbers on Controlled Substance Prescription Forms

Indiana Board of Pharmacy regulation *856 IAC 1-34-2(a)(9)* requires that "all controlled substance prescriptions written by licensed Indiana practitioners, as defined by Indiana code (IC) *IC 16-42-19-5*, must contain the practitioner name and state issued professional license number." The state issued professional license number "must be preprinted, stamped, or manually printed on the prescription." Additionally, the IHCP requires the eight-digit prescriber license number on all pharmacy claims. Out-of-state providers should see the section below titled *State-Issued Professional License Number.*

The review showed numerous instances where controlled substance prescriptions and drug claim forms did not contain the required prescriber license number. In some instances, the drug claim form contained an incorrect prescriber license number.

Prescriber Signature on Controlled Substance Prescription Forms

Regulation *856 IAC 2-6-4* requires that "all prescriptions for controlled substances shall be dated as of, and signed on, the day when issued.... A practitioner may sign a prescription in the same manner as he would sign a check or legal document. The prescriptions may be prepared by a secretary or agent for the signature of a practitioner, but the prescribing practitioner is responsible in case the prescription does not conform in all essential respects to the law and regulations. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by these regulations."

Records maintained by some pharmacies show prescriptions for controlled substances (not received by telephone) that did not contain a prescriber signature. Filling prescriptions that do not contain the prescriber signature is in violation of pharmacy law and can result in recoupment of IHCP funds and referral to the Indiana Board of Pharmacy.

Collection of Copayments

Regulation *405 IAC 5-24-7* requires that "the copayment shall be paid by the recipient and collected by the provider at the time the service is rendered.... The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid." However, the member cannot be denied the prescription if unable to meet the copayment requirement. Certain exceptions to this rule apply such as emergency services; services to individuals younger than 18 years old; services to pregnant women; inpatients in a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), or other institution; family planning services; and health maintenance organization (HMO) pharmacy services.

Circumstances were found where pharmacies did not charge applicable copayments to members. Additionally, instances were noted where pharmacy records indicated copayments were collected from nursing facility residents, a practice that is contrary to the IHCP rule. Applicable copayments must be charged to members, and copayments cannot be charged to members who qualify for the exceptions explained previously.

Dispensing of Brand Name Drugs/Mandatory Substitution

Regulation *IC 16-42-22-10* states, all pharmacies are to "substitute a generically equivalent drug product and inform the customer of the substitution if the substitution would result in a lower price unless: (1) the words 'Brand Medically Necessary' are written in the practitioner's own writing on the form; or (2) the practitioner has indicated that the pharmacist may not substitute a generically equivalent drug product by orally stating that a substitution is not permitted. If a practitioner orally states that a generically equivalent drug product may not be substituted, the practitioner must subsequently forward to the pharmacist a written prescription with the Brand Medically Necessary

instruction appropriately indicated in the physician's own handwriting." When the words *brand medically necessary* are stated on the prescription, a generic drug cannot be dispensed.

Records maintained by some pharmacies show instances in which prescriptions were dispensed with brand name drugs rather than a generic equivalent when the prescription did not contain the words *brand medically necessary* written in the prescriber's own handwriting and a generic version was available. The review also noted prescriptions filled with generic equivalents when the prescription contained the words *brand medically necessary* in the prescriber's handwriting.

Multiple Dispensing Fees

Regulation *405 IAC 5-24-6(b)* requires that "a maximum of one (1) dispensing fee per month is allowable per recipient per drug order for legend drugs provided to Medicaid recipients residing in Medicaid certified long term care facilities."

The review revealed some pharmacies received multiple dispensing fees within a month (defined as a 28-day period) for the same legend drug order for a member in an IHCP-certified long term care facility. Enhancements were made to the claims processing system to better enforce this policy; nonetheless, it is a pharmacy provider's responsibility to ensure these overpayments are promptly refunded to the IHCP. Providers must submit all refunds for overpayments to ACS at the following address:

Indiana Pharmacy Claims
c/o ACS
P. O. Box 502327
Atlanta, GA 31150

Brand Medically Necessary *Overrides on Claims for* Generic *Drugs*

Regulation *405 IAC 5-24-4* specifies that reimbursement for legend drugs is based on "the lowest of the following: (1) The estimated acquisition cost (EAC) of the drug as of the date of dispensing, plus any applicable Medicaid dispensing fee; (2) The maximum allowable cost (MAC) of the drug as determined by the Health Care Financing Administration, under *42 CFR 447.332* as of the date of dispensing, plus any applicable Medicaid dispensing fee; (3) The state maximum allowable cost (MAC) of the drug as determined by the office as of the date of dispensing, plus any applicable Medicaid dispensing fee; or (4) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing."

The review revealed some pharmacy providers received additional reimbursement due to specifying an *06 – Brand medically necessary override* on the drug claim when billing for *generic* drug products and when the prescriber did not specify *brand medically necessary*. Specifying *brand medically necessary* on a claim for a generic drug is an error. This prompted Indiana*AIM* to suspend pricing at the otherwise applicable MAC rate for the presumably dispensed generic drug. This resulted in payment to the provider at a higher rate than what would have occurred had the MAC pricing not been inappropriately suspended because the pharmacy provider specified *brand medically necessary* on a claim for a generic drug.

Note: Providers are advised that purposefully receiving higher reimbursement than what is entitled by indicating brand medically necessary *when dispensing a generic drug product is considered fraud, and could subject the provider to removal from the IHCP, and prosecution by the appropriate state and federal agencies.*

In BT200330 May 22, 2003, Pages 4 and 5 of the bulletin do not pertain to generics and are not included here.

For Additional Information

Direct questions about this bulletin to Myers and Stauffer LC, at (317) 846-9521, extension 345.

Indiana Health Coverage Programs Pharmacy Provider Reviews
BT200330 May 22, 2003
EDS -- Five Pages
P. O. Box 7263 Indianapolis, IN 46207-7263 For more information visit www.indianamedicaid.com

Attachment 6

DUR Program Evaluation:
Impact Assessment and Savings Analyses

CMS FFY 2003 - INDIANA MEDICAID DUR PROGRAMS

DUR Program Evaluation Overview

Table of Contents – Attachment 6

A summary description of the types of DUR Program analyses included in this Attachment 6 is as follows:

DUR Program Estimated Savings Analysis

An evaluation of the effectiveness of ProDUR and estimated savings (costs avoided) of the ProDUR edits is given in Attachment 6.1.

Estimated utilization and savings generated as a result of the RetroDUR program is also given in Attachment 6.1. An evaluation of the effectiveness of the RetroDUR program is measured in terms of:

a) Number of prescrip tions reduced or increased (depending upon the criteria and intervention's goal); and,
b) Estimated savings by total dollars saved and dollars saved per utilizing recipient per year.

IRDP Prior Authorization Evaluation

An evaluation of the effectiveness of some of the ProDUR hard edits called the Indiana Rational Drug Program (IRDP) requiring a Prior Authorization to override is presented in Attachment 6.2.

PDL Prior Authorization Evaluation & Savings Analysis

An evaluation of the effectiveness of the ProDUR hard edits requiring a Prior Authorization to fill a prescription for Nonpreferred drugs is presented in Attachment 6.3. Percentage market share shifts and an annualized savings analyses attributed to the PDL program are included.

Deleted: non-preferred

IMPACT EVALUATION OF INDIANA MEDICAID PROSPECTIVE AND RETROSPECTIVE DRUG UTILIZATION REVIEW PROGRAMS:

A Utilization and Savings Analyses

Prepared for:

State of Indiana Office of Medicaid Policy and Planning

October 1, 2002 – September 30, 2003

PREPARED BY: Michelle Laster-Bradley, Ph.D., R.Ph

ACS State Healthcare Solutions, PBM Group

ACS State Healthcare Solutions©

Under the Direction of
State of Indiana Office of Medicaid Policy and Planning
and
The State of Indiana Drug Utilization Review (DUR) Board

6/18/2004

Executive Summary: Drug Use Review (DUR) Analyses

All drug treatments carry some possibility of adverse effects and drug-induced disease. Drug therapy is such an integral part of health care that the need to identify, prevent and monitor adverse drug effects is more critical than ever. The risk grows as patients receive treatment for multiple medical conditions. Drugs prescribed for one condition may conflict with those prescribed for other conditions. In addition, mis-prescribing and providing inappropriate drug therapy can also endanger patients' health just as much as adverse effects.

Many clinical factors influence prescription decisions, including the patient's health status, side effects reported by the patient or detected by the physician, and available alternative treatments. To prescribe appropriately, the practitioner needs all relevant clinical and personal information, including the drugs ordered by other practitioners. In the modern healthcare system, few practitioners are fully aware or fully knowledgeable about all drugs and supplements their patients may receive.

Non-clinical factors also come into the equation. Fragmented health care, increased volume of patients seen, and proliferating drugs, diagnostics, and medical specialties increasingly complicate the task of prescribing optimal therapy. In addition, the pharmaceutical industry funds research to determine how to influence prescribers' decisions. Then pharmaceutical companies aggressively market their products, using paid advertising targeted toward practitioners and patients. Lastly, patients may consult a variety of practitioners, which increases the risk of mis-prescribing and drug-induced disease.

DUR serves a vital monitoring purpose by:

- Consolidating each patient's drug therapy history in a single, usable database.
- Analyzing that history using sophisticated clinical criteria.
- Identifying potential drug therapy problems such as drug-disease conflicts, drug-drug interactions, over-utilization, under-utilization, and clinical or therapeutic appropriateness.
- Notifying and presenting apparent drug therapy problems to practitioners and/or pharmacists.

Prospective DUR (ProDUR) and retrospective DUR (RetroDUR) each serve a unique purpose in providing practitioners and pharmacists with specific, focused and comprehensive drug information available from no other source. DUR allows practitioners to make timely changes in prescriptions and keeps these problems from growing. If practitioners and pharmacists use DUR as intended, then notification of a potential drug therapy problem will lead to appropriate action taken in response to a ProDUR alert or RetroDUR event. Actions include discontinuing unnecessary prescriptions, reducing quantities of medications prescribed, switching to safer drug therapies, or even adding a therapy recommended in published guidelines from an expert panel.

Timely DUR warnings along with practitioners' and pharmacists' appropriate actions can

prevent adverse effects and mis-prescribing which lead to complications, hospitalizations, and treatment (which ultimately increases costs). Recipients avoid complications and harm, and State Medicaid programs are spared needless expense.

In sum, both ProDUR and RetroDUR serve vital functions. If DUR is widely and properly used by State Medicaid programs, their contractors and Medicaid providers, then the State Medicaid DUR programs provide an added margin of safety to its recipients and avoid unnecessary medical, hospital, and prescription drug expenses.

Overall Medicaid Pharmacy Program Costs

In response to growing Medicaid costs, the Indiana Office of Medicaid Policy and Planning (OMPP) has worked to implement a large number of policy changes aimed at containing costs while improving quality care to Medicaid recipients over the past 2 years.

> For FFY 2003, Indiana Office of Medicaid Policy and Planning has succeeded in slowing the rate of growth in its Medicaid FFS prescription drug costs to well below the national average, (2.0% vs. approximately 4%).

OMPP has succeeded in slowing the rate of growth in its Medicaid prescription drug budget well below the national average. The state of Indiana spent $655,998,166 in FFY 2002 and $668,857,411 in FFY 2003 reflecting a 1.9% increase in prescription drug costs on a paid basis, and 0.2% on an incurred basis. This is a success considering the growth rate in prescription drug costs have increased nationally in the double-digits each year since 1994 (See Table I) and well ahead of the overall national rate of inflation (2% for the past two years 2001-2003, according to the Bureau of Labor Statistics).

Table I. Indiana Medicaid Drug Costs Compared to National Averages

INDIANA MEDICAID PHARMACY FEE FOR SERVICE TOTAL DRUG COSTS (PAID BASIS)		% Increase from Prior Year**	National Annual Change per Capita*
State FY 2002	$649,455,800		
State FY 2003	$636,906,424	-(1.9%)	
FFY 2002	$649,878,900		
FFY 2003	$663,237,000	2.0%	4%
Calendar Year 2001	$615,472,871		13.8%
Calendar Year 2002	$653,736,700	5.9%	13.2%
Calendar Year 2003	$673,154,750	2.9%	(Jan-Jun) 8.5%

* Sources: Health care spending data are the Milliman USA Health Cost Index ($0 deductible); Inflation rate is from the U.S. Bureau of Labor Statistics.

**Source: Figures are for paid basis & do not include medical supplies that have since been discontinued billing by NDC.

Drug Utilization Review (DUR) Programs

The DUR programs have saved money by encouraging quality, medically necessary and appropriate drug therapy in order to reduce total healthcare expenditures. For the CMS Federal Fiscal Year 2003, estimated prescription drug savings resulting from ProDUR and RetroDUR programs is shown in Table II. Summary analyses for FFY 2003 in Table II are reported as prescription drug savings.

Drug savings estimates from DUR programs are measured by the actual claims before and after interventions.

The total estimated drug cost savings over the CMS Federal Fiscal Year 2003 for Indiana for ProDUR and RetroDUR programs are $6,131,715. When adding PDL program savings to ProDUR and RetroDUR, the estimated program net savings are $7,041,265.

Table II. Indiana Program Impact Evaluation: Estimated Drug Cost Savings

Estimated Total Costs Avoided[1] or Savings Per Year		State Program Costs Per Year	Net Savings for FFY 2003 and Return On Investment (ROI)
ProDUR	**$ 3,881,664**	$8,000,000*	Program Net Savings **$7,041,265** **For each $1 spent, the state saved $1.32 or 132%** The state lost some rebate revenue from the PDL program; but all ACS' services* paid for themselves plus obtained a return on investment.
PDL	**$12,434,379**		
(savings net rebates) =	$ 8,909,550		
RetroDUR	**$ 2,250,051**		
Total Savings ONLY ProDUR & RetroDUR	**$ 6,131,715**		
GRAND TOTAL SAVINGS (ProDUR, RetroDUR & PDL)	**$18,566,094**		
Savings net rebates from PDL= $15,041,265			

1.Reported "costs avoided" dollar amounts are state and federal combined.

*** NOTE: The $8M reflects the entire cost of the contract that includes far more than DUR. Contract activities include, but are not limited to: POS claims processing, paper claims processing, rebate management, cost containment initiatives, audit services, provider relations, T- Committee / DUR Board support, PDL administration, rebates, 24 hour help desk support, website development and maintenance, reporting and analysis, all Hoosier Rx activities, TAI/IBM RetroDUR, and clinical program analysis & expertise. Therefore, the cost of running the entire Medicaid pharmacy program through ACS State Healthcare Solutions pays for itself with these three programs with a return on investment of over 100%.**

OMPP and the DUR Board have always been interested in the impact that the programs

implemented have on quality of care and upon medical costs. Appendix 6.3 contains a summary of a more detailed study on the impact of the PDL program on quality of care conducted by ACS State Healthcare for OMPP. Each evaluation of medical costs and utilization measured inpatient hospital, outpatient hospital, physician office visits and emergency room services. Outcomes reports were produced by linking recipients to medical claims incurred before and after prescription(s) that were affected by the PDL program were submitted and/or paid.

In each study, there appeared to be no statistically significant impact on recipients in terms of adverse outcomes. Because the PDL study was limited to paid claims data, a limitation existed in that outcomes could not be fully evaluated.

The health care services included in the study were physician office visits, inpatient hospital admissions, and emergency room visits. Having identified recipients affected by the program, outcomes reports were produced by linking these recipients to medical claims incurred following the prescription involved in the intervention.

DUR Background and History

-- Title XIX SSA § 1927(g)(2)(C); 42 CFR Part 456; 57 FR (No. 212) 49397-49412

Title XIX of the Social Security Act authorizes grants to States for medical assistance to needy individuals (Medicaid). Each state decides eligible groups, types and ranges of s ervices, payment levels for most services, and administrative and operating procedures. Coverage of prescription drugs may be provided as an optional service. For the state of Indiana, the federal portion of payment responsibility for these drugs and services (or the "Federal Medical Assistance Percentage" [FMAP]) for the 1st and 2nd quarters of FFY 2003 is 61.97%. Pursuant to Title IV of the Jobs and Growth Tax Relief Reconciliation Act of 2003, the Medicaid FMAPs were revised and increased. The increased FMAPs used in determining the amount of Federal matching for State medical assistance (Medicaid) expenditures under Title XIX, are effective only for the last 2 calendar quarters of FFY 2003 (64.99% from April 1 through September 30, 2003), and the firs t 3 quarters of FFY 2004 (65.27% from October 1, 2003 through June 30, 2004) (http://www.aspe.hhs.gov/health/FMAP03-04temporaryincrease.html).

Why DUR? OBRA '90

Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) added a new Section 1927 to the Social Security Act, Title XIX. Section 1927(g) provides that for states to receive federal funds for outpatient drugs, the State must have a comprehensive Medicaid drug use review (DUR) program in place by January 1, 1993 and that the program was to be on going. The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), formerly Health Care Financing Administration (HCFA), is the agency responsible for promulgating rules to enforce the intent of Congressional law, Title XIX SSA Section 1927(g). CMS' rules regarding Drug Use Review Programs in the Medicaid Program are listed in 42 CFR Part 456 and 57 FR (No. 212) 49397-49412.

Purpose of OBRA 90

OBRA 90 Approach to Savings

To save taxpayer money by increasing pharmacist responsibility for patient outcomes with drug therapy.

The objective was to save taxpayer money by reducing the cost of drug therapy for Medicaid patients. The legislation's approach was innovative. Congress recognized that the one approach to achieving Medicaid cost savings was to increase pharmacist responsibility for patient outcomes with drug therapy. Congress recognized the potential for pharmacists to reduce Medicaid drug expenditures because of their visibility, knowledge, training, and patients' ready access to them.

Purpose of DUR

Purpose of Medicaid Outpatient DUR

To improve quality of pharmaceutical care by ensuring that prescription drugs are:

- Appropriate,
- Medically necessary, &
- Not likely to result in adverse medical events.

The purpose of Medicaid outpatient DUR was, and still is, to improve the quality of pharmaceutical care by ensuring that prescription drugs are appropriate, medically necessary and that they are not likely to result in adverse medical events.

Programs Required by OBRA '90

OBRA 90 mandated the outpatient, comprehensive Medicaid DUR program to consist of:

- Prospective DUR (ProDUR)
- Retrospective DUR (RetroDUR)
- Use of Predetermined Standards in administering ProDUR and RetroDUR programs
- Educational and Training Programs
- Outcomes Measurement for On-going Evaluation of the DUR programs

Use of Predetermined Standards in Administering ProDUR and RetroDUR Programs

Title XIX SSA § 1927(g)(2)(C); 42 CFR Part 456.703(e, f) & Part 456.705(b)

Problem Categories Required by OBRA 90

Drug therapy problems can be grouped into one of several categories for both ProDUR and RetroDUR as follows:

- Over-Utilization
- Under-Utilization
- Therapeutic Appropriateness
- Therapeutic Duplication
- Drug-Disease (or Drug-Inferred Disease) Contraindications
- Incorrect Dose
- Incorrect Duration of Treatment
- Drug-Drug Interactions
- Appropriate Use of Generic Products
- Clinical Abuse & Misuse

(42 CFR Part 456.705[b], 42 CFR Part 456.709[b]; 57 FR 49399,49401-49402)

DUR Criteria

States or their contractors are to perform claims reviews by applying predetermined standards. Predetermined standards are developed to monitor drug therapy problems by problem categories (listed above). Each state determines its own standards and criteria for both ProDUR and RetroDUR within the framework outlined in the problem categories. OBRA 90 only requires that the criteria be consistent with standard, accepted reference sources of drug information, such as U.S. Pharmacopoeia Drug Information, American Hospital Formulary Service Drug Information, AMA Drug Evaluations, and/or peer-reviewed literature (42 CFR Part 456.703[e, f]).

The criteria are to be reviewed and approved in each state by a non-biased, scientific state DUR Board. The criteria allow computer programs to screen prescription claims submitted to state Medicaid for potential drug therapy problems, to determine the clinical significance, and to set alerts. The state Medicaid agency or its contractor is to conduct awareness strategies and

educational interventions based upon these alerts either prospectively (at the point of sale before the prescription is filled) or retrospectively (after the prescription is filled). The goal is to improve prescribing, dispensing, and recipient drug use patterns. Congress and CMS hoped that encouraging appropriate use and discouraging inappropriate use of prescription drugs would result in saving money and avoiding costly payments for Medicaid programs.

Steps of the OBRA 90 General DUR Process

The primary functions involved in a DUR program are summarized as follows.

1. Develop Standards & Educational Strategies
    a. Screen claims for common drug therapy problems using predetermined standards
    b. Identify areas where predetermined standards may need to be applied.
    c. Present standards and/or criteria to the DUR Board for adoption/rejection.
    d. Identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs or groups of drugs.

2. Review Claims and Profiles
    a. Apply predetermined standard(s) to the most recent 3 to 6-months drug claims history and about 12-months of medical history.
    b. Conduct at least quarterly reviews of profiles of Medical Assistance recipients whose utilization are outliers from predetermined standard of care.
    c. Review prescribing and dispensing patterns of physicians, nurse practitioners, and pharmacists compared to the norms established by peers (Identify outliers of predetermined standards).

3. Conduct Educational Interventions with Prescribers and Pharmacists
    a. Apply pre-defined educational and awareness strategies, based upon results of reviews.
    b. Goal of educational strategies is to improve prescribing, dispensing, or recipient utilization patterns.
    c. Distribute patient profiles and associated recommendations, if necessary, to practitioners.

4. Assess impact of educational interventions to determine if costs were reduced, utilization changed (depending upon the criterion's goal), or if quality of care improved.

5. Modify educational programs and predetermined criteria for greater impact.

6. Start process over again with Step 1.

Prospective DUR

Title XIX SSA § 1927(g)(2)(A); 42 CFR Part 456.705

OBRA '90 expanded DUR to pharmacists in outpatient community pharmacies via the Prospective DUR component. Prospective DUR places responsibility for the patient's medication use upon the pharmacist before a prescription is dispensed and delivered to the patient. The intent was to require pharmacists to detect problems with drug therapy before a prescription is filled or delivered; thereby, improve care and reduce costs at the same time.

With Prospective DUR, the pharmacist is required to conduct a review of the prescription drug order prior to dispensing. States were encouraged to implement Prospective DUR by enhanced federal funding to design and install point-of-sale electronic claims management systems that interface with their MMIS operations. Computer programs with Prospective DUR criteria screen the claims against predetermined criteria before a prescription is dispensed and look to see if a single prescription is in conflict with any other prescription. Computer programs such as electronic claims management systems with ProDUR edits can facilitate screening but they do not replace pharmacists' professional judgment.

State of Indiana ProDUR Edit Statistics

Table 1 from the CMS Annual Report document (pages 10-21) lists the ProDUR criteria by problem categories that are currently active in the state of Indiana Point of Sale (POS) claims processing system within the Indiana Medicaid pharmacy program. Attachment 2 from the CMS Annual Report document (pages 34-66) gives the ProDUR activity statistics, and this attachment, Attachment 6.A, estimates the cost savings resulting from the ProDUR activities.

Retrospective DUR

Title XIX SSA § 1927(g)(2)(B); 42 CFR Part 456.709

Whereas Prospective DUR looks to see if a single prescription is in conflict with any other prescription, Retrospective DUR applies clinical criteria and predetermined standards to evaluate patients' entire clinical picture *after* medications are dispensed to patients.

Purpose of Retrospective DUR

The purpose of Retrospective DUR is to assist practitioners by calling their attention to potential adverse drug effects and inappropriate prescribing. Physicians and other practitioners need to know whenever such a possibility exists. To prescribe appropriately, the practitioner needs all relevant clinical and personal information, including the drugs ordered by other practitioners.

Types of Retrospective DUR Analyses

Retrospective DUR involves monthly or quarterly pattern analysis, reviews, education, and reporting of three categories:

1. **Drug Utilization** by Individual Recipients
2. **Prescribing Practices** of Physicians
3. **Dispensing Practices** of Pharmacies (42 CFR Part 456.709[a]).

Value of Retrospective DUR

The unique value of Retrospective DUR is four-fold. RetroDUR enables states to have a complete therapeutic review program that:

- Defines cost effective therapy in terms of **total patient outcomes**.
- Anticipates and **prevents future problems** by reviewing the entire history, identifying & educating providers.
- Maximizes taxpayer dollars by only **targeting providers** who need education.
- **Identifies patterns** of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care among practitioners, pharmacists, and recipients. Patterns are identified within specific drugs, therapeutic classes, or specific groups of drugs abused or inappropriately utilized.

By retrospectively examining patterns, better, more effective policy decisions to improve drug therapy can be made. For example, retrospective pattern analysis can give insight into which ProDUR hard edits should be added or changed. Furthermore, education can be targeted and funds can be conserved, maximizing effectiveness. For example, instead of conducting an antibiotic resistance reduction program over the entire state, funds can be targeted only to a certain geographic area where antibiotic over-prescribing patterns have been observed. Likewise, retrospective analyses can improve the success of a Preferred Drug List, targeted letters and academic detailing.

State of Indiana RetroDUR Edit Statistics

Table 2 lists the RetroDUR criteria by problem categories that have been approved by the DUR Board for the Indiana Medicaid pharmacy program over the prior Federal Fiscal Year. Attachment 3 gives the RetroDUR activity statistics, and Attachment 6.B estimates the savings resulting from any RetroDUR interventions performed in the FFY 2003.

The state of Indiana used three types of RetroDUR interventions:

1. Letter interventions termed regular RetroDUR mailings;
2. Phone calls termed Intensive Benefits Management (IBM); and,
3. Academic detailing termed Therapeutic Academic Interventions (TAI) or TAI visits.

The intervention letter describes the potential drug therapy problem in a patient-specific situation, and may include a current month's comprehensive drug history profile. The IBM

interventions involve ACS pharmacists calling practitioners to discuss the particular drug therapy problem and any other problems observed on each patient's therapy profile, using medical as well as pharmacy data. Knowledgeable IBM pharmacists discuss with practitioners changes in patient(s)' therapy to more appropriate drug therapy; discuss various alternatives with practitioners; and, educate practitioners about avoiding the drug therapy problem in future prescribing. With TAI, an ACS pharmacist conducts face-to-face office visits with targeted practitioners to educate them on observed prescribing patterns involving drug therapy problems with their patients. TAI interventions also involve large group meetings with targeted practitioners about drug therapy problems that are occurring on a large scale. Inappropriate prescribing and utilization is discussed face-to-face.

Educational and Training Programs

Title XIX SSA §1927(g)(2)(B); 42 CFR 456.711

Goal of Education Programs

The goal of education and training programs is to improve prescribing and dispensing practices - by identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, and/or medically inappropriate or medically unnecessary care among physicians, pharmacists and recipients.

Types of Educational Interventions

Under the requirements, educational components within the DUR programs must include the following interventions:

a. Dissemination of information to physicians and pharmacists in the State concerning:
   1) Duties and powers of the DUR Board; and,
   2) Individual State requirements for counseling by pharmacists of recipients or recipient's caregivers about their medications when performing Prospective DUR.

b. Written, oral, or electronic reminders containing patient-specific or drug-specific information (or both) and suggested changes in prescribing or dispensing practices.

c. Face-to-face discussions between experts in appropriate drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices." Follow-up discussions are to occur when necessary.

d. Intensified review or monitoring of selected prescribers or dispensers.

DUR Board

Title XIX SSA Section 1927(g)(2)(3) and 42 CFR Part 456.716

OBRA 90 required that States establish a DUR Board, either directly or through contract with a private contractor. The DUR Board serves as an expert advisory panel to the Indiana Office of Medicaid Policy and Planning. After the State OMPP personnel and the contractor have researched and developed educational program ideas, they are presented to the DUR Board for review and feedback.

The DUR Board determines the content and circumstances when the educational interventions are to be used. The DUR Board is also tasked with making recommendations as to which combinations of interventions listed previously would most effectively lead to improvement in the quality of drug therapy.

OBRA 90, and subsequently CMS, mandated specific requirements on the qualifications of Board members and to the composition and activities of the Board. Congress' purpose in establishing specific qualifications, composition, and activities was to ensure that a panel of skilled professional medical and pharmacy personnel would be assembled without conflicts of interest and biases toward or against certain drugs or practices. The state of Indiana has since added state law on DUR and duties of the DUR Board under Indiana Code (Section 17. IC 12-15-35-28).

DUR Board Composition and Qualifications

According to federal regulations, the DUR Board must be comprised of health care professionals who have recognized knowledge and expertise in at least one of the following:

- Clinically appropriate prescribing of covered outpatient drugs
- Clinically appropriate dispensing of covered outpatient drugs
- Drug use review, evaluation, and intervention
- Medical quality assurance (42 CFR Part 456.716).

At least 1/3 but not more than 51% of DUR Board members must be physicians, and at least 1/3 must be pharmacists. These physicians and pharmacists must be actively practicing and licensed by the state of the DUR Board upon which they are serving. The state Medicaid agency, e.g. OMPP, has the authority to accept or reject the recommendations or decisions of the DUR Board.

DUR Board Activities Under Code of Federal Regulations (CFR)

According to federal regulations, the activities of the DUR Board are as follows:

- Review and make recommendations on predetermined standards, educational topics, and educational interventions submitted to it by the state Medicaid agency or its contractor.
- Evaluate the use of the predetermined standards, and make recommendations for addition, modification, or elimination.
- Identify, develop, and advise on educational topics if education of practitioners is needed

to improve prescribing and/or dispensing practices.

- Make recommendations on the combination of interventions that would most effectively lead to improvement in the quality of drug therapy.

DUR Board Duties under Indiana Code

According to Indiana state law, IC 12-15-35-28, Sec. 28. (a) The board has the following duties:

(1) The adoption of rules to carry out this chapter, in accordance with the provisions of IC 4-22-2 and subject to any office approval that is required by the federal Omnibus Budget Reconciliation Act of 1990 under Public Law 101-508 and its implementing regulations.

(2) The implementation of a Medicaid retrospective and prospective DUR program as outlined in this chapter, including the approval of software programs to be used by the pharmacist for prospective DUR and recommendations concerning the provisions of the contractual agreement between the state and any other entity that will be processing and reviewing Medicaid drug claims and profiles for the DUR program under this chapter.

(3) The development and application of the predetermined criteria and standards for appropriate prescribing to be used in retrospective and prospective DUR to ensure that such criteria and standards for appropriate prescribing are based on the compendia and developed with professional input with provisions for timely revisions and assessments as necessary.

(4) The development, selection, application, and assessment of interventions for physic ians, pharmacists, and patients that are educational and not punitive in nature.

(5) The publication of an annual report that must be subject to public comment before issuance to the federal Department of Health and Human Services and to the Indiana legislative council by December 1 of each year.

(6) The development of a working agreement for the board to clarify the areas of responsibility with related boards or agencies, including the following:
(A) The Indiana board of pharmacy.
(B) The medical licensing board of Indiana.
(C) The SURS staff.

(7) The establishment of a grievance and appeals process for physicians or pharmacists under this chapter.

(8) The publication and dissemination of educational information to physicians and pharmacists regarding the board and the DUR program, including information on the following:

(A) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients.
(B) Potential or actual severe or adverse reactions to drugs.
(C) Therapeutic appropriateness.
(D) Over utilization or underutilization.
(E) Appropriate use of generic drugs.
(F) Therapeutic duplication.
(G) Drug-disease contraindications.

(H) Drug-drug interactions.
(I) Incorrect drug dosage and duration of drug treatment.
(J) Drug allergy interactions.
(K) Clinical abuse and misuse.

(9) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program that identifies individual physicians, pharmacists, or recipients.

(10) The implementation of additional drug utilization review with respect to drugs dispensed to residents of nursing facilities shall not be required if the nursing facility is in compliance with the drug regimen procedures under 410 IAC 16.2-3-8 and 42 CFR 483.60.

(11) The research, development, and approval of a preferred drug list for:
(A) Medicaid's fee for service program;
(B) Medicaid's primary care case management program; and
(C) the primary care case management component of the children's health insurance program under IC 12-17.6; in consultation with the therapeutics committee.

(12) The approval of the review and maintenance of the preferred drug list at least two (2) times per year.

(13) The preparation and submission of a report concerning the preferred drug list at least two (2) times per year to the select joint commission on Medicaid oversight established by IC 2-5-26-3.

(14) The collection of data reflecting prescribing patterns related to treatment of children diagnosed with attention deficit disorder or attention deficit hyperactivity disorder.

Outcomes Measurement: CMS Philosophy on Evaluation of DUR Programs

Title XIX SSA § 1927(g)(3)(D); 42 CFR Part 456.709, 456.712[a,b]

The Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Finance Administration (HCFA), requires each state Medicaid Drug Utilization Review (DUR) Program submit an annual report. The CMS annual report provides a measurement tool to assess how well states have implemented DUR programs and the effect DUR has had on patient safety, practitioner prescribing habits and dollars saved by avoidance of drug therapy problems. As part of the annual report, each state is to estimate the savings attributable to prospective and retrospective DUR, and to report the costs of DUR program operations.

The CMS contracted a panel of advisors in 1994 with extensive experience in both DUR and program evaluation studies to develop the " *Guidelines for Estimating the Impact of Medicaid DUR."*[1] The guidelines were developed because the CMS recognized the difficulty in producing legitimate estimates of s avings associated with DUR programs with an acceptable level of rigor given very real operational and resource limitations. Studies must be rigorous enough to be confident that the results are attributable to DUR activities. Yet, analysts and researchers cannot interfere with day-to-day operations and cannot require unrealistic resources to conduct the studies.

In explaining why the Guidelines were developed, the expert panel of authors state: *"Attributing changes in prescribing and patient outcomes to DUR is a complex process...While rigorous studies are preferred in principle, they often [are not feasible].*

"*Applying the concepts embodied in these guidelines has the potential to do more than just help states fulfill their obligations for the annual report required by Federal law*." *[The guidelines can]"provide states with approaches that will help them analyze and improve DUR operations."*[2] Additionally, if comparable estimation procedures are followed among the state Medicaid agencies, then information can be shared and compared, permitting states to learn from one another's experiences.

[1] Zimmerman, T. Collins, E. Lipowski, D. Kreling, J. Wiederholt. "Guidelines for Estimating the Impact of Medicaid DUR." Contract #500-93-0032. United States Department of Health and Human Services, Health Care Financing Administration: Medicaid Bureau. August 1994

[2] CMS *Guidelines for Estimating the Impact of Medicaid DUR* 1994, p. 1

Outcomes Measurement for State of Indiana DUR Programs

ACS' Approach to Evaluation

The 1994 CMS "*Guidelines for Estimating the Impact of Medicaid DUR"* (Contract # 500-93-0032) is an excellent operational research methods guideline that is still as relevant and useful ten years later. ACS State Healthcare Solutions employs health services researchers and scientists who strongly believe in following the 1994 CMS "*Guidelines for Estimating the Impact of Medicaid DUR*" (Contract # 500-93-0032). Therefore, analyses and cost estimates presented in this report are all acceptable methods listed in the CMS Guidelines as procedures that are likely to produce legitimate estimates of the cost savings (or cost avoidance) associated with DUR programs. This should give both CMS and the state of Indiana Office of Medicaid Policy and Planning (OMPP) a high degree of confidence that the results can be attributed to its DUR activities and not to other events.

According to estimates, between 3-28% of all hospital admissions involve adverse drug effects. Eliminating inappropriate drug use will eliminate the cost of unnecessary medical and hospital care. The cost of mis-prescribed drugs is small relative to unnecessary medical and hospitalization costs; but, drug costs are much easier to measure than trying to estimate treatments and hospital admissions that may have been as a result of inappropriate use. On the other hand, under-use or lack of use of certain indicated drugs can cause unnecessary medical, hospital, and emergency room care. Lack of prescribing or noncompliance with an indicated drug may have a small impact on drug costs, but may drive up medical, hospitalization, and emergency room costs with a larger impact.

To examine the impact of DUR interventions on medical costs avoided, both Medstat (IRDP analyses) and ACS (PDL analyses) examined medical utilization and costs in intervention recipients versus comparison recipients in whom no interventions took place. In each instance, there was no evidence that overall medical costs were any different between the two groups. Savings are reported for the ProDUR and RetroDUR programs separately.

ProDUR Impact Analysis & Outcomes Measurement: State of Indiana

ProDUR Edits Methodology

In presenting our analyses, ProDUR is defined as "*a review of prescription orders and other reports for an individual patient or provider which is performed at the point of service (POS)…The review occurs as the medication is dispensed. Thus the evaluation of prospective DUR differs [from RetroDUR evaluation] in that it is necessary to* ***estimate the number and nature of drug use problems averted and the cost avoided***."[3] The estimated ProDUR savings calculation reflects only those claims that were submitted electronically.

[3] CMS *Guidelines for Estimating the Impact of Medicaid DUR* 1994, p. 2

If a ProDUR alert is triggered upon submission of a claim, the pharmacist must respond to the alert in order to proceed with the claim. The response is captured electronically. By responding to the alert, the claim may be adjudicated, and the pharmacist would thereby dispense the medication. The pharmacist's response to the initial ProDUR alert could produce savings from costs avoided if the action taken by the pharmacist prevented an adverse drug-related event or enhanced the effectiveness of the patient's drug therapy. Conversely, the pharmacist's response could also reflect an increase in program costs if the result was the utilization of more costly drug therapy.

Study Scope

The period for measuring cost avoidance (savings associated with the ProDUR program) is all prescription drug claims submitted during FFY 2003 (10/1/02 to 9/30/03). These data reside in the claims history warehouse. Results of ProDUR alerts are examined by month over the FFY 2003.

According to the CMS Guidelines, it is not acceptable to limit the DUR savings results to global estimates of savings in the drug budget or overall Medicaid expenditures. ProDUR savings estimates should specifically track result relative to individual cases affected by ProDUR alerts.[4] One cannot sum dollar amounts associated with all denials and/or reversals and claim these are the total ProDUR cost savings either. The reason is one cannot assume that all denials of prescriptions through on-line ProDUR edits results in changes in drug use and expenditures. If the claim is filled with a substitute medication or is delayed by several days in filling, we should track the net effects upon expenditures. Likewise, one must use caution in estimating the costs avoided from "reversal" of claims and only measure costs avoided from true reversals that stay reversed. Tracking and calculating costs associated with actions resulting from ProDUR edit alerts have always been difficult at best. Comparison group designs are normally recommended; however, with on-line ProDUR, comparison populations who are not receiving an alert are not possible.

To achieve an acceptable method of estimating ProDUR savings, a computerized tracking method, Claims Tracking and Intervention Assessment Coding System (CTIACS), was developed to follow a claim from the initial alert, through the series of alerts and possible adjustments, and then ultimately to payment, substitution of alternative therapy, or final denial of each prescription "hitting" a ProDUR alert. Cost avoidance or savings for ProDUR is measured based upon several general claims scenarios after claims are submitted shown in Table III.

[4] CMS *Guidelines for Estimating the Impact of Medicaid DUR* 1994, p. 4

Table III. Outcomes and Savi ngs Produced for ProDUR Edit Response Scenarios

Claims Scenario	Pharmacist Response	Outcomes Produced	Savings Result
Denied, Not Resubmitted	Cancel Prescription	Don't fill inappropriate medication	Savings associated with lack of filling Rx *(Amount that would have paid)**
	No Response	Don't fill inappropriate medication & no re-submission	Savings for the *Amount that would have paid** had the prescription been filled.
Denied, Resubmitted & then Paid upon resubmission	No Response; but, Resubmits Prescription later	Delay in filling; e.g. wait 7 days for an Early Refill alert and resubmit on the correct date	Savings associated with delay in filling (Payment amounts adjusted by delays in filling). Very difficult to attach a cost estimate. No Estimated Savings Obtained
	No Response; but, Submits a Different Claim	Original claim not paid; Substitute Claim Submitted	Savings are what would have been paid for the first claim (cost avoided) and what is paid for the 2nd submission; e.g. Brand Medically Necessary alert hitting on a ProDUR alert for generic available.*
	Adjust Prescription Claim & Resubmit	Original claim not paid; Substitute Claim Submitted	Savings are Cost avoided with 1st claim minus cost of alternate taken; e.g. hitting on a ProDUR alert for quantity limits or excessive duration.
Paid	No Alert	No Alert	No Estimated Savings Obtained
Post Alert Info only & Paid	Fill Prescription; Receive Alert message after Paid	Fill prescription as is	Costs can be associated with RPh talking to MD or patient. Very difficult to attach a cost estimate. No Estimated Savings Obtained
Post, Override & Paid	Override Alert; Fill prescription with minor adjustments not trackable through on-line systems	Fill prescription as is with possible adjustment other than Rx.	Either increased savings or increased costs can be associated with adjusting the prescription. Very difficult to attach a cost estimate. No Estimated Savings Obtained
Post, Paid, then Reversed by RPh	Reversal of Rx	Don't fill medication	If reversal was resubmitted within the month of service, then counted as savings. Savings Obtained from Reversal

* Amount that would have been paid is defined as the amount allowed for the prescription if the claim had not hit the ProDUR alert.

Methods & Data Sources

Each alert resulting from the on-line ProDUR system is counted as an intervention. The total number of alerts and responses are reported on the EDS ProDUR Attachment 2.1.A and the ACS ProDUR Attachment 2.1.B.

During the EDS claims processing period, 10/1/02 to 3/22/2003, tracking of the claims was not possible using "paid" and "denied" status codes. We can only report savings associated with tracking claims when ACS began adjudicating March 23, 2003.

ACS State Healthcare's system tracks thenon-responses through to a final paid or denied claim using a *unique identifier* (TCN plus prescription number plus GCN). Other assumptions with this tracking method are:

a.) If a drug substitution was made and the prescription number did not change, then the savings was calculated.

Savings (or actually costs avoided) were calculated as the difference between the amount that would have paid on the initial submission and the amount paid on the substitute claim. If the claim was cancelled and a new prescription started, then the savings could not be calculated. For example, if a claim "hits" the alert that generic substitution is required, the pharmacist most likely will use the same prescription number, change the drug name, and resubmit the claim. It was assumed that this scenario did not happen often and costs avoided or incurred would be negligible.

b.) Duplicate claims for the same prescription drug and refill number (same unique identifier) counted as savings only once.

c.) Duplicate edits for the same unique identifier could not be eliminated. For example, if a claim denied for the ProDUR Drug-Drug alert and again for Ingredient Duplication, both denials were counted as costs avoided. Some would argue that only one ProDUR alert should be included in costs avoided and we agree. However, there was no way to systematically remove these without manually checking millions of rows of data. We acknowledge that the duplicate alerts are a limitation of the measurement for costs avoided.

d.) Only the true ProDUR edits were included in savings estimates. Point of sale technology can produce additional savings with implementing hard edits, stopping quantity errors during submission, requiring prior authorization (PA) and strict formularies such as a Preferred Drug Lis t (PDL) program. PA and PDL savings were not included in the ProDUR "soft" edit savings estimates.

e.) At times a billing error generated a ProDUR edit alert, such as "High Dose Alert" or "Excessive Duration Alert" for a mis-billed quantity. According to the CMS guidelines, "these types of savings should **not** be claimed as DUR savings" (CMS Guidelines 1994, p. 33). These savings or costs avoided were filtered out of ACS'

claims tracking system as much as feasible, specifically for savings > $2,000; however, there may have been some that were missed from the filtering process. This may result in a slight over-estimation of these types of costs avoided.

For final denied claims (Status=D and Adjustment Status Code=0), the amount that would have been paid or Amount Allowed for each ProDUR unique identifier is the costs avoided or savings. Since amount allowed was not carried forward with denied claims, an Estimated Amount Paid was calculated to come as close to amount allowed as possible. Billed Amount was not used because billed amounts could be any amount pharmacists wanted to input and did not nearly approximate Amount Allowed. In fact, using Billed Amount would have excessively overestimated Amount Allowed or costs avoided.

To calculate Savings for each Unique ProDUR Identifier, Estimated Amount Paid was subtracted from Total Paid for the prescription. If the claim were denied outright, then amount paid was zero and Estimated Amount Paid was used.

Example Calculations of ProDUR Savings along with equations used are included in Table IV.

Table IV. Example Calculations of ProDUR Cost Avoidance in ACS' System

Adjustment Status Codes Valid Values: 0 = original claim; 1 = adjusted original claim or reversed claim; 2= voided claim, or adjustment of a previously adjusted claim
Status Codes : P=Paid, D=Denied

IN ProDUR Unique Identifier ID = Concatenation of Pharmacy ID+ SysID + GCN

Avg Price = Unit Price of the Drug - used in conjunction with Drug Pricing Type
Estimated Amount Paid = ((<Avg Price>*<Billed Qty (Total)>)*0.88)
Total PAID for Rx = <Amount Paid (Total)>+<TPL Amount (Total)>

SAVINGS = If <Total PAID for Rx>< 0 Then (<Total PAID for Rx>) Else If <Adjustment Status Code>="0" And<Status Code>="P" Then 0 Else If <Adjustment Status Code>="1" Then <Total PAID for Rx> Else If <Adjustment Status Code>="0" And<Status Code>="D" Then (<Estimated Paid Amt>-<Total PAID for Rx>)

IN ProDUR unique Identifier	Drug Name	Status Code	Treatment Status Code	Reason for Svc Code	Billed Qty (Total)	Avg Billed Amt	Amount Paid (Total)	Rx Count	Estimated Paid Amt	Total PAID for Rx	Savings
10001216DA181 99736591	TOPAMAX 100MG TABLET	P	0	TD	150	$629.99	$492.14	1	$499.74	$492.14	$0.00
10001216DA181 55741597	KEPPRA 500MG TABLET	P	0	LD	30	$159.16	$114.74	1	$356.43	$114.74	$0.00
10001216DA181 55741597	KEPPRA 500MG TABLET	P	0	TD	30	$159.16	$114.74	1	$356.43	$114.74	$0.00
10001216DA181 55702219	ZONEGRAN 100MG CAPSULE	P	0	TD	60	$317.98	$229.04	1	$114.58	$229.04	$0.00
10001216DA400 54964317	LAMICTAL 25MG TABLET	D	0	PA	120	$787.98	$0.00	2	$317.01	$0.00	$317.01
10001216DA400 54964317	LAMICTAL 25MG TABLET	D	0	TD	120	$787.98	$0.00	3	$317.01	$0.00	$317.01
10001216DA400 54964317	LAMICTAL 25MG TABLET	P	0	TD	120	$380.88	$633.02	2	$317.01	$633.02	$0.00
10001216DA485 32714281	ALPRAZOLAM 0.5MG TABLET	P	0	TD	90	$21.89	$7.02	1	$78.34	$7.02	$0.00
10001216DA971 66226323	SYNTHROID 100MCG TABLET	P	0	TD	30	$32.18	$25.60	1	$11.09	$25.60	$0.00
10001880A690 0441681	ALBUTEROL .83MG/ML SOLUTION	P	0	TD	360	$230.00	$90.36	1	$127.77	$90.36	$0.00
10002182DA1 06403168181	SYNAGIS 100MG VIAL	P	0	TD	1	$2,623.12	$1,139.40	1	$1,154.17	$1,139.40	$0.00
10002182DA1 06907050397	SYNAGIS 50MG VIAL	D	0	TD	1	$1,389.18	$0.00	1	$811.24	$0.00	$811.24
10002182DA1 06907050397	SYNAGIS 50MG VIAL	P	0	TD	1	$1,389.18	$605.72	1	$811.24	$605.72	$0.00
10002182DA1 06955168181	SYNAGIS 100MG VIAL	P	0	TD	1	$2,623.12	$1,139.40	1	$1,164.17	$1,139.40	$0.00
10002182DA1 06758868181	SYNAGIS 100MG VIAL	D	0	TD	1	$2,623.12	$0.00	1	$1,164.17	$0.00	$1,164.17
10002182DA1 06758068181	SYNAGIS 100MG VIAL	P	0	TD	1	$2,623.12	$1,139.40	1	$1,164.17	$1,139.40	$0.00
10002182DA3 82419848	MORPHINE SULFATE 50MG/ML VL	P	0	TD	100	$1,542.24	$2,523.36	5	$391.80	$2,523.36	$0.00
10002182DA3 3574940051	CLAFORAN 20M VIAL	D	0	TD	28	$2,179.52	$0.00	1	$547.93	$0.00	$547.93
10002182DA8 02054251 14	PROCRIT 2000CU/ML VIAL	D	0	TD	1	$534.24	$0.00	1	$235.07	$0.00	$235.07
10002182DA8 02054251 14	PROCRIT 2000CU/ML VIAL	P	0	TD	1	$534.24	$215.10	1	$235.07	$215.10	$0.00
10002182DA8 02054251 15	PROCRIT 4000CU/ML VIAL	P	0	TD	1	$1,050.48	$353.58	2	$470.13	$353.58	$0.00
10002443DA1 73821250B9	HUMATROPE 6MG CARTRIDGE	D	0	TD	6	$1,573.01	$0.00	1	$1,595.30	$0.00	$1,595.30
10002530DA5 0953029B2	SODIUM CHLORIDE 0.9% SOLN	P	0	TD	10	$29.59	$4.48	1	$0.09	$4.48	$0.00
10002530DA6 0953038B4	SODIUM CHLORIDE 0.9% VIAL	D	0	TD	14	$56.14	$0.00	1	$0.69	$0.00	$0.69
10002530DA6 44071029B2	SODIUM CHLORIDE 0.9% SOLN	P	0	TD	2000	$327.69	$186.10	2	$64.13	$186.10	$0.00
10005251 0A1 19980183B7	ZETIA 10MG TABLET	D	0	HD	30	$113.99	$0.00	2	$83.89	$0.00	$83.89
10005251 0A1 19980183B7	ZETIA 10MG TABLET	D	0	TD	37	$83.55	$0.00	3	$78.56	$0.00	$78.56
10005251 0A1 19980206B6	ZOCOR 80MG TABLET	D	0	TD	16	$141.36	$0.00	3	$60.53	$0.00	$60.53
10005251 0A1 23230163B2	TRAZODONE 100MG TABLET	D	0	ID	30	$33.36	$0.00	1	$18.34	$0.00	$18.34
10005251 0A1 23230163B2	TRAZODONE 100MG TABLET	D	0	TD	30	$33.36	$0.00	1	$18.34	$0.00	$18.34
10005251 0A1 23230163B2	TRAZODONE 100MG TABLET	P	0	ID	30	$16.69	$7.14	1	$18.34	$7.14	$0.00
10005251 0A1 13898167B2	SEROQUEL 100MG TABLET	D	0	LD	30	$181.38	$0.00	1	$79.87	$0.00	$79.87
10005251 0A1 13898167B2	SEROQUEL 100MG TABLET	D	0	TD	30	$181.38	$0.00	1	$79.87	$0.00	$79.87
10005251 0A1 13764570331	HYDROCODONE/APAP 5/500 TAB	D	0		120	$41.63	$0.00	1	$49.09	$0.00	$49.09
10005251 0A1 13764570331	HYDROCODONE/APAP 5/500 TAB	D	0	TD	120	$41.63	$0.00	2	$49.09	$0.00	$49.09
10005251 0A1 14150225794	WARFARIN SODIUM 2.5MG TAB	P	0	TD	12	$8.69	$8.19	1	$6.84	$8.19	$0.00
10005251 0A1 14150225796	WARFARIN SODIUM 3MG TABLET	P	0	TD	30	$18.69	$17.62	1	$16.85	$17.62	$0.00
10005251 0A1 16755536551	TOPAMAX 100MG TABLET	P	0	LD	30	$231.36	$189.80	1	$89.75	$189.80	$0.00
10005251 0A1 16755536551	TOPAMAX 100MG TABLET	P	0	TD	30	$231.36	$189.80	1	$89.75	$189.80	$0.00
10005251 0A1 16755570394	HYDROCODONE/APAP 10/500 TAB	D	0	TD	180	$46.86	$0.00	3	$84.38	$0.00	$84.38
10005251 0A1 17514901772	NITROQUICK 0.4MG TABLET SL	D	0	TD	25	$21.73	$0.00	2	$4.02	$0.00	$4.02
10005251 0A1 21137069B0	AMARYL 1MG TABLET	P	0	TD	30	$18.68	$10.69	1	$8.84	$10.69	$0.00

ProDUR Alert Activity Results

The total number of alerts and responses are captured on the EDS ProDUR report (Attachment 2.1.A) and the ACS ProDUR report (Attachment 2.1.B). The reports summarize the actions taken by pharmacists when presented with ProDUR alerts in the course of dispensing prescriptions to Indiana Medicaid recipients. EDS reported 652,345 ProDUR alerts as the contractor from 10/1/2002 to 2/7/2003. ACS State Healthcare reported 1,735,196 ProDUR alerts as the contractor from 3/23/03 to 9/30/03 for a ***total of 2,387,541 ProDUR alerts for FFY 2003***. ProDUR alerts for the period 2/8/2003 to 3/22/03 are not included due to the POS system transition from EDS to ACS (data not available from EDS during this time period).

ProDUR Savings Results in FFY 2003

Table V shows savings summed by ProDUR Alert and overall alerts.

Table V. Sum of Costs (State and Federal) Avoided by ProDUR Alert for FFY 2003

ALERT TYPE	Number of Rx's	Cost Savings
Early Refill (ER)	44,639	$2,536,872.33
Therapeutic Duplication (TD)	7,789	$502,277.26
Drug-Drug Interaction (DD)	10,919	$484,018.44
High Dose (HD)	658	$88,474.90
Ingredient Duplication (ID)	3,191	$221,548.39
Drug-Pregnancy (PG)	5	$43.68
Drug-Gender (SX)	1	$1,153.00
Low Dose (LD)	334	$26,324.90
Pediatric (PA)	20	$2,284.41
Late Refill/Underuse (LR)	32	$578.34
Drug Inferred Disease (DC)	23	$1,888.50
GRAND TOTAL	**64,043**	**$3,881,664**

According to the Claims Tracking and Intervention Assessment Coding System (CTIACS system), costs avoided as a result of ProDUR edits were $3.8 million for FFY 2003.

ProDUR Discussion and Conclusion

As revealed in this report, ProDUR is working and saved the state approximately $3.8 million dollars in FFY 2003. The establishment of "hard alerts"—that is, ProDUR alerts that require a prior authorization from ACS—ensured that program savings are being maximized and that alerted claims are medically necessary, reasonable, and appropriate.

ACS staff, in conjunction with the state's DUR Board and OMPP staff, will continue to monitor and evaluate the state's ProDUR experience in order to continually improve the ProDUR system. Clearly, a benefit is gained by all (the State, the provider community, and the beneficiary population served).

RetroDUR Impact Analysis & Outcomes Measurement: State of Indiana

RetroDUR Methodology Impact Analysis

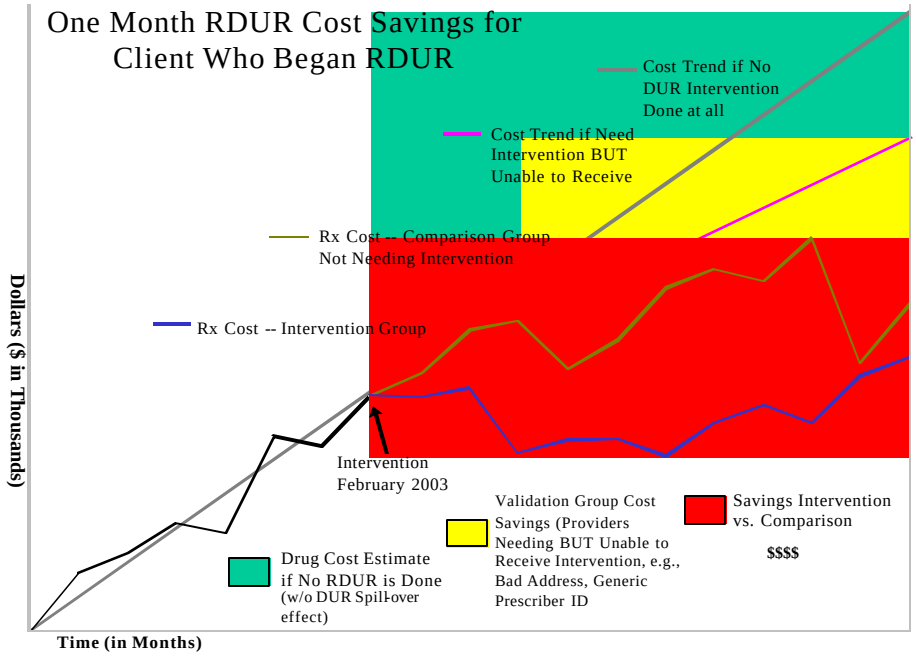
The state of Indiana ensured that a CMS-compliant claims tracking methodology was used to evaluate the results of the RetroDUR program. The Claims Tracking of Interventions and Analysis of Cost Savings (CTIACS) system identifies changes in drug therapy patterns following the intervention and measures the monetary impact of these changes.

The 1994 CMS report, " Guidelines for Estimating the Impact of Medicaid DUR", was used to develop the methodology for measuring the impact of the Retrospective DUR program. Simply stated, the preferred and recommended method of the 1994 CMS guidelines is a scientifically sound methodology that involves comparison of all recipients who received interventions (intervention group) with those who did not receive interventions (comparison group). This preferred comparison group method has the most validity and accuracy of any other method (Zimmerman, T. Collins, E. Lipowski, D. Kreling, J. Wiederholt. "Guidelines for Estimating the Impact of Medicaid DUR." (Contract #500-93-0032, United States Department of Health and Human Services, Health Care Financing Administration: Medicaid Bureau, August 1994).

The intervention population, a subset of beneficiaries, includes all recipients confirmed as having inappropriate drug therapies and who were intervened upon during the analysis period. Interventions included sending an Alert Letter and patient profile to every prescriber involved in the drug therapy problem(s) in addition to answering questions on the 800-DUR hotline. It is possible to track the cost impact upon recipients upon whom we intervene (called 'cases'). Reports can be generated for cost savings and number of prescriptions saved per patient case or per recipient (if a recipient has more than one case).

To confirm the validity of our methodology, initially two comparison groups were evaluated along with an intervention group for cost savings. One comparison group, called the conservative comparison group, was an equal subset of patients who were taking medication involved in the alert, but needed no intervention. The second comparison group, used for validation, was patients who needed an intervention but no intervention was possible. The largest reason was that the prescriber couldn't be identified; for example, the prescriber's correct address couldn't be found or the pharmacy used an invalid or generic prescriber number in filing the claim. The following graph illustrates a very conservative estimate of cost savings obtained using our selected comparison group. The graph also illustrates how the validation group's costs continue to rise when they needed a letter more so than the comparison groups' costs.

Figure 2.



Overall Procedures

ACS' outcomes measures of therapy improvements and cost savings are not dependent upon receiving prescriber responses about the letters, since what practitioners *say* is not an accurate measure of actual behavior. Instead, actions are measured from claims data to determine what prescribing patterns have actually changed as a result of educational interventions. Drug savings estimates from RetroDUR are measured by the claims 180-days before and after interventions.

To analyze recipients' drug use, we followed the 1994 CMS "Guidelines for Estimating the Impact of Medicaid DUR." We compared the cost of all prescription drugs for each recipient before and after physicians received Alert letters, phone calls or face-to-face visits. By following CMS's guidelines, our analysis measured "the substitution effect." That is, prescribers may substitute another drug in the same therapeutic class in place of the drug about which the Alert letter was sent. Therefore, our analysis also included the cost of other drugs in the same therapeutic class. We calculated each period's costs using the exact quantities of each drug dispensed and the claims costs (defined as: reimbursement formula specified in the plan).

For the purpose of this report, cases were analyzed using 180 days of claims data before and after the alert letter/intervention month. The number of prescriptions and cost of drug therapy were then compared for the pre - and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for

each case was evaluated compared to a comparison group. Anything that happens to one group will also affect the other group and will negate any outside effects on drug costs. Any savings that occurred can then be attributed to the DUR intervention and not some other effect.

RetroDUR Results

The following information is a year-end analysis of RetroDUR activities and outcomes that were approved by the DUR Board and performed by ACS pharmacists through their three RetroDUR program types: Intensified Benefits Management (IBM), Therapeutic Academic Intervention (TAI) and regular RetroDUR Programs.

ACS found that for the October 1, 2002 to September 30, 2003 period, 70,400 recipients were reviewed and 45,301 recipients of 9,455 prescribers were targeted for RetroDUR interventions. Estimated annual savings* for the FFY 2003 were $ 2,250,051.

ENTIRE RETRO-DUR PROGRAM COMBINED	# PTS REVIEWED	# PTS INTERVENED	# PRESCRIBERS TARGETED		INTERVENTION MONTH SAVINGS	PROJECTED ANNUAL SAVINGS	PROJECTED SAVINGS $PUPYear
	70,400	45,331	9,455		$187,504.27	$2,250,051.24	$1,370.56
				GRAND TOTAL All RetroDUR Interventions =		$2,250,051	

* All amounts are reported as state and federal Medicaid dollars combined.

ACS RetroDUR Grand Summary

The Outcomes Analyses Tables for each RetroDUR intervention type is included in the Appendices. Tables include cost savings as well as the number of prescriptions saved per intervention cycle per month and by program (IBM/TAI or Regular RetroDUR). Real savings, while controlling for changes over time, were calculated using the comparison and intervention groups.

We found the intervention group total prescription drug costs typically decreased following Alert letters, phone calls or site visits; whereas, the comparison group (who needed intervention but did not receive intervention) prescrip tion costs typically continued to increase. The letter intervention involving overuse of short-acting inhaled beta-agonists was not expected to save money ($808 annual savings), but was a quality of care intervention on therapeutic inappropriateness. The recommendation was to increase the use of inhaled corticosteroids costing more prescription dollars in order to prevent overuse of rescue inhalers. Overuse of rescue inhalers indicates lack of asthma control, poor quality of life, and ultimately, increas ed medical costs.

RetroDUR Discussion

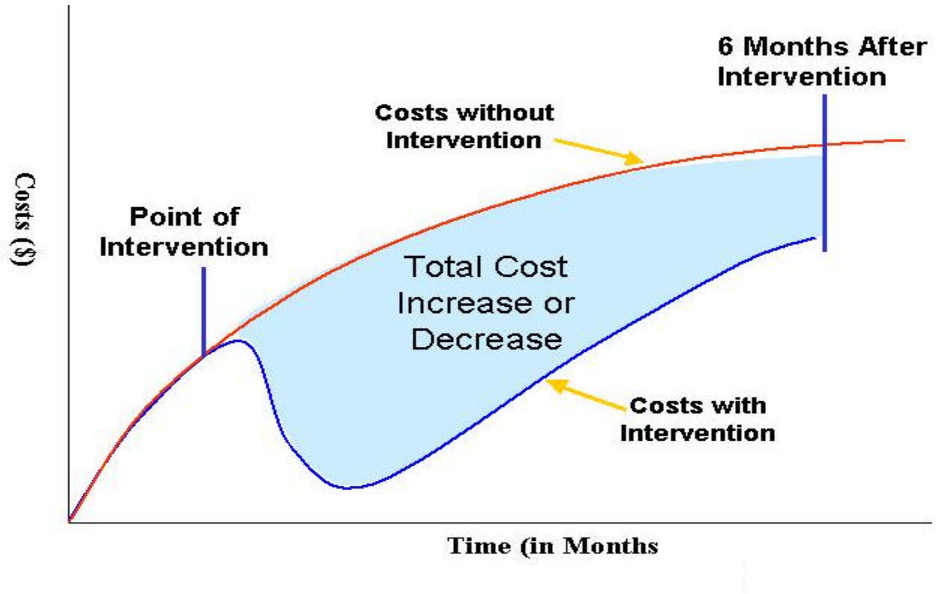
In our experience, drug costs decrease soon after an intervention, then costs remain relatively flat or only slightly increase for approximately 6 months. After about 6 months post-intervention, drug costs in the intervention group will start to climb again as indicated by the upward slope on

Graph 2; but, costs never reach the point of the comparison group drug cost trends (See Graph 2). The comparison group illustrates what would happen to drug costs if no DUR program interventions were undertaken.

The psychological theory of the *primacy-recency effect* can explain this phenomenon where interventions work for several months, but do not contain costs permanently. Practitioners must be reminded periodically of the intervention criteria. The most recent events are what practitioners primarily recall when they are choosing drug therapy for patients. State Medicaid agencies are trying to provide optimal care while keeping costs reasonable should likewise take advantage of the primacy-recency effect by repeated ProDUR *and* RetroDUR educational interventions on practitioners who do not meet the predetermined standards or criteria set by the DUR Board. Graph 2 illustrates this primacy-recency concept quite vividly.

In sum for DUR overall, the general trend for comparison group recipients is for drug costs to continue to rise. The trend for intervention group recipients is for drug costs to either remain flat (meaning rising drug costs have been contained) or to decrease over a 6-month time frame.

Graph 2



DUR Program Evaluation Conclusions

Outcomes analyses were conducted on actual prescriber behavior rather than prescriber responses to letter interventions. Outcomes analyses shows that DUR **does work** in general and specifically, has worked for State of Indiana. Furthermore, the State of Indiana Drug Utilization Review program provides an important quality assurance service to Medical Assistance recipients.

Over the CMS Federal Fiscal Year 2003 year, the program confirmed 1.7 million incidences where recipients were at risk for drug therapy problems in the ProDUR program and 70,400 incidents in the RetroDUR program. These recipients were at increased risk of dangerous adverse drug effects and drug-induced diseases. Cost savings were reported for each drug therapy problem and for each intervention type to illustrate that some criteria focusing on certain drug therapy problems were more effective at reducing prescription drug utilization and drug costs than other criteria (See Appendices).

The total net drug cost savings (or costs avoided) over the FFY 2003 for ProDUR POS edit and RetroDUR clinical programs (IBM, TAI, and RetroDUR letter) was $6.13 million.[1]

Adding the ProDUR, RetroDUR and PDL prior authorization program savings, the total estimated net savings was $18.6 million.[2]

The drug cost savings for DUR programs alone was a return on investment (ROI) of 132%[3], meaning that for every dollar spent on the DUR program, State of Indiana received $1.32 in drug savings.

1. **Reported "costs avoided" dollar amounts are state and federal combined.**
2. **Savings were $15,041,265 net rebate losses from the PDL program; however, the return on investment was still close to 100%.**
3. **Return on investment calculation includes the cost of all ACS services to the State of Indiana.**

ATTACHMENT 6.1.A IBM INTERVENTIONS – OUTCOMES

INTENSIFIED BENEFITS MANAGEMENT (IBM) PROGRAM

OCTOBER 2002 ASSESSMENT SUMMARY

INTERVENTION-- Use of Non-Preferred ACE Inhibitors

Number of Recipients Targeted	1610
Number of Prescribers Targeted	685
Method of Intervention	Call

CONTROL: UTILIZERS ON ACE INHIBITORS

Inter-vention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	July 2002 - Sept 2002	$1,876,625.87	44,288	$42.37	20,304	$30.81	0.73	$156,752.11	5,776	$1,719,873.76	38,512
Post	Nov 2002 - Jan 2003	$952,368.93	21,291	$44.73	9,424	$33.69	0.75	$233,998.96	7,037	$718,369.97	14,254
	Difference	-$924,256.94	-22,997	$2.36	-10,880	$2.88	0.03	$77,246.85	1,261	-$1,001,503.79	-24,258
	% Change	-49.25%	-51.93%	5.56%	-53.59%	9.34%	3.58%	49.28%	21.83%	-58.23%	-62.99%

INTERVENTION: TARGETED UTILIZERS ON ACE INHIBITORS

Inter-vention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	July 2002 - Sept 2002	$82,633.91	2,168	$38.12	805	$34.22	0.90	$2,590.85	101	$80,043.06	2,067
Post	Nov 2002 - Jan 2003	$54,927.67	1,793	$30.63	664	$27.57	0.90	$16,967.52	698	$37,960.15	1,095
	Difference	-$27,706.24	-375	-$7.48	-141	-$6.64	0.00	$14,376.67	597	-$42,082.91	-972
	% Change	-33.53%	-17.30%	-19.63%	-17.52%	-19.41%	0.26%	554.90%	591.09%	-52.58%	-47.02%

NOVEMBER 2002 ASSESSMENT SUMMARY

INTERVENTION -- Use of Non-Preferred Thiazolidinediones

Number of Recipients Targeted	1514
Number of Prescribers Targeted	736
Method of Intervention	Call

CONTROL: ALL UTILIZERS ON NON-PDL THIAZOLIDINEDIONES

Inter-vention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Aug 2002 - Oct 2002	$1,934,429.36	13,168	$146.90	5,694	$113.24	0.77	$0.00	0	$1,934,429.36	13,168
Post	Dec 2002 - Feb 2003	$218,853.12	1,573	$139.13	1,499	$48.67	0.35	$0.00	0	$218,853.12	1,573
	Difference	-$1,715,576.24	-11,595	-$7.77	-4,195	-$64.58	-0.42	$0.00	0	-$1,715,576.24	-11,595
	% Change	-88.69%	-88.05%	-5.29%	-73.67%	-57.03%	-54.62%	0.00%	0.00%	-88.69%	-88.05%

INTERVENTION: TARGETED UTILIZERS ON NON-PDL THIAZOLIDINEDIONES

Inter-vention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Aug 2002 - Oct 2002	$571,178.56	3,992	$143.08	1,470	$129.52	0.91	$0.00	0	$571,178.56	3,992
Post	Dec 2002 - Feb 2003	$47,379.32	344	$137.73	333	$47.43	0.34	$0.00	0	$47,379.32	333
	Difference	-$523,799.24	-3,648	-$5.35	-1,137	-$82.09	-0.56	$0.00	0	-$523,799.24	-3,659
	% Change	-91.70%	-91.38%	-3.74%	-77.35%	-63.38%	-61.96%	0.00%	0.00%	-91.70%	-91.66%

PAGE 2 **IBM INTERVENTIONS –OUTCOMES**

"-- continued--" INTENSIFIED BENEFITS MANAGEMENT (IBM) PROGRAM

DECEMBER 2002 ASSESSMENT SUMMARY

INTERVENTION -- Use of Non-Preferred Angiotensin Receptor Blockers (ARBs)

Number of Recipients Targeted	1686
Number of Prescribers Targeted	912
Method of Intervention	Call

CONTROL: ALL UTILIZERS ON NON-PDL Angiotensin Receptor Blockers (ARBs)

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Sept 2002 - Nov 2002	$469,763.30	9,636	$48.75	4,798	$32.64	0.67	$0.00	0	$469,763.30	9,636
Post	Jan 2003 - Mar 2003	$45,444.60	1,138	$39.93	1,012	$14.97	0.37	$0.00	0	$45,444.60	1,138
	Difference	-$424,318.70	-8,498	-$8.82	-3,786	-$17.67	-0.29	$0.00	0	-$424,318.70	-8,498
	% Change	-90.33%	-88.19%	-18.09%	-78.91%	-54.13%	-44.01%	0.00%	0.00%	-90.33%	-88.19%

INTERVENTION: TARGETED UTILIZERS ON NON-PDL Angiotensin Receptor Blockers (ARBs)

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Sept 2002 - Nov 2002	$211,086.78	4,545	$46.44	1,686	$41.73	0.90	$0.00	0	$211,086.78	4,545
Post	Jan 2003 - Mar 2003	$19,499.84	462	$42.21	359	$18.11	0.43	$0.00	0	$14,749.68	366
	Difference	-$191,586.94	-4,083	-$4.24	-1,327	-$23.63	-0.47	$0.00	0	-$196,337.10	-4,179
	% Change	-90.76%	-89.83%	-9.12%	-78.71%	-56.62%	-52.26%	0.00%	0.00%	-93.01%	-91.95%

JANUARY 2003 ASSESSMENT SUMMARY

INTERVENTION -- Use of Non-Preferred SERM Bone Resorption Agents

Number of Recipients Targeted	1313
Number of Prescribers Targeted	588
Method of Intervention	Call

CONTROL: ALL CONTROL UTILIZERS ON NON-PDL SERMS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Oct 2002 - Dec 2002	$140,443.32	2,650	$53.00	997	$46.96	0.89	$0.00	0	$140,443.00	2,650
Post	Feb 2003 - April 2003	$35,807.97	1,281	$27.95	508	$23.50	0.84	$0.00	0	$35,807.97	1,281
	Difference	-$104,635.35	-1,369	-$25.04	-489	-$23.46	-0.05	$0.00	0	-$104,635.03	-1,369
	% Change	-74.50%	-51.66%	-47.26%	-49.05%	-49.96%	-5.13%	0.00%	0.00%	-74.50%	-51.66%

INTERVENTION: ALL TARGETED UTILIZERS ON NON-PDL SERMS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Oct 2002 - Dec 2002	$147,205.94	2,794	$52.69	1,056	$46.47	0.88	$0.00	0	$147,205.94	2,794
Post	Feb 2003 - April 2003	$46,170.74	817	$56.51	598	$25.74	0.46	$0.00	0	$46,170.74	817
	Difference	-$101,035.20	-1,977	$3.83	-458	-$20.73	-0.43	$0.00	0	-$101,035.20	-1,977
	% Change	-68.64%	-70.76%	7.26%	-43.37%	-44.61%	-48.36%	0.00%	0.00%	-68.64%	-70.76%

PAGE 3 **IBM INTERVENTIONS –OUTCOMES**

"-- continued--" INTENSIFIED BENEFITS MANAGEMENT (IBM) PROGRAM

DECEMBER 2002 ASSESSMENT SUMMARY

INTERVENTION -- Use of Non-Preferred Angiotensin Receptor Blockers (ARBs)

Number of Recipients Targeted	1686
Number of Prescribers Targeted	912
Method of Intervention	Call

CONTROL: ALL UTILIZERS ON NON-PDL Angiotensin Receptor Blockers (ARBs)

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Sept 2002 - Nov 2002	$469,763.30	9,636	$48.75	4,798	$32.64	0.67	$0.00	0	$469,763.30	9,636
Post	Jan 2003 - Mar 2003	$45,444.60	1,138	$39.93	1,012	$14.97	0.37	$0.00	0	$45,444.60	1,138
	Difference	-$424,318.70	-8,498	-$8.82	-3,786	-$17.67	-0.29	$0.00	0	-$424,318.70	-8,498
	% Change	-90.33%	-88.19%	-18.09%	-78.91%	-54.13%	-44.01%	0.00%	0.00%	-90.33%	-88.19%

INTERVENTION: TARGETED UTILIZERS ON NON-PDL Angiotensin Receptor Blockers (ARBs)

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Sept 2002 - Nov 2002	$211,086.78	4,545	$46.44	1,686	$41.73	0.90	$0.00	0	$211,086.78	4,545
Post	Jan 2003 - Mar 2003	$19,499.84	462	$42.21	359	$18.11	0.43	$0.00	0	$14,749.68	366
	Difference	-$191,586.94	-4,083	-$4.24	-1,327	-$23.63	-0.47	$0.00	0	-$196,337.10	-4,179
	% Change	-90.76%	-89.83%	-9.12%	-78.71%	-56.62%	-52.26%	0.00%	0.00%	-93.01%	-91.95%

JANUARY 2003 ASSESSMENT SUMMARY

INTERVENTION -- Use of Non-Preferred SERM Bone Resorption Agents

Number of Recipients Targeted	1313
Number of Prescribers Targeted	588
Method of Intervention	Call

CONTROL: ALL CONTROL UTILIZERS ON NON-PDL SERMS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Oct 2002 - Dec 2002	$140,443.32	2,650	$53.00	997	$46.96	0.89	$0.00	0	$140,443.00	2,650
Post	Feb 2003 - April 2003	$35,807.97	1,281	$27.95	508	$23.50	0.84	$0.00	0	$35,807.97	1,281
	Difference	-$104,635.35	-1,369	-$25.04	-489	-$23.46	-0.05	$0.00	0	-$104,635.03	-1,369
	% Change	-74.50%	-51.66%	-47.26%	-49.05%	-49.96%	-5.13%	0.00%	0.00%	-74.50%	-51.66%

INTERVENTION: ALL TARGETED UTILIZERS ON NON-PDL SERMS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Oct 2002 - Dec 2002	$147,205.94	2,794	$52.69	1,056	$46.47	0.88	$0.00	0	$147,205.94	2,794
Post	Feb 2003 - April 2003	$46,170.74	817	$56.51	598	$25.74	0.46	$0.00	0	$46,170.74	817
	Difference	-$101,035.20	-1,977	$3.83	-458	-$20.73	-0.43	$0.00	0	-$101,035.20	-1,977
	% Change	-68.64%	-70.76%	7.26%	-43.37%	-44.61%	-48.36%	0.00%	0.00%	-68.64%	-70.76%

PAGE 4 **IBM INTERVENTIONS –OUTCOMES**

"-- continued --" INTENSIFIED BENEFITS MANAGEMENT (IBM) PROGRAM

JULY 2003 ASSESSMENT SUMMARY

INTERVENTION -- SSRI DOSE OPTIMIZATION - Conversion from BID dosing to QD of higher strength.

Number of Recipients Targeted	979
Number of Prescribers Targeted	788
Method of Intervention	Call

CONTROL: NON TARGETED UTILIZERS ON GREATER THAT 1 DOSE DAILY SSRIs

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Apr 2003 - Jun 2003	$259,590.98	1,804	$143.90	697	$124.15	0.86	$0.00	0	$259,590.98	1,804
Post	Aug 2003 - Sept 2003	$212,386.81	1,671	$127.10	638	$110.96	0.87	$0.00	0	$212,386.81	1,671
	Difference	-$47,204.17	-133	-$16.80	-59	-$13.18	0.01	$0.00	0	-$47,204.17	-133
	% Change	-18.18%	-7.37%	-11.67%	-8.46%	-10.62%	1.19%	0.00%	0.00%	-18.18%	-7.37%

INTERVENTION: TARGETED UTILIZERS ON GREATER THAT 1 DOSE DAILY SSRIs

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Apr 2003 - Jun 2003	$273,583.02	2,711	$100.92	979	$93.15	0.92	$0.00	0	$273,583.02	2,711
Post	Aug 2003 - Sept 2003	$222,972.61	2,371	$94.04	884	$84.08	0.89	$0.00	0	$222,972.61	2,371
	Difference	-$50,610.41	-340	-$6.87	-95	-$9.07	-0.03	$0.00	0	-$50,610.41	-340
	% Change	-18.50%	-12.54%	-6.81%	-9.70%	-9.74%	-3.14%	0.00%	0.00%	-18.50%	-12.54%

SEPTEMBER 2003 ASSESSMENT SUMMARY

INTERVENTION -- High Utilizers

Number of Recipients Targeted	500
Number of Prescribers Targeted	756
Method of Intervention	Call

CONTROL: SECOND TOP 500 UTILIZERS BASED ON NUMBER OF PRESCRIPTIONS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Jun 2003 - Aug 2003	$1,487,354.19	32,592	$45.64	500	$991.57	21.73	$283,105.79	18,613	$1,203,631.49	13,979
Post	Oct 2003 - Dec 2003	$1,169,114.38	25,745	$45.41	465	$838.07	18.46	$194,227.70	14,617	$974,550.46	11,128
	Difference	-$318,239.81	-6,847	-$0.22	-35	-$153.49	-3.27	-$88,878.09	-3,996	-$229,081.03	-2,851
	% Change	-21.40%	-21.01%	-0.49%	-7.00%	-15.48%	-15.06%	-31.39%	-21.47%	-19.03%	-20.39%

INTERVENTION: TARGETED TOP 500 UTILIZERS BASED ON NUMBER OF PRESCRIPTIONS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Jun 2003 - Aug 2003	$1,805,044.41	40,590	$44.47	500	$1,203.36	27.06	$340,236.27	24,171	$1,464,067.42	16,419
Post	Oct 2003 - Dec 2003	$1,189,570.89	27,219	$43.70	438	$905.31	20.71	$210,304.71	15,879	$979,092.74	11,340
	Difference	-$615,473.52	-13,371	-$0.77	-62	-$298.06	-6.35	-$129,931.56	-8,292	-$484,974.68	-5,079
	% Change	-34.10%	-32.94%	-1.72%	-12.40%	-24.77%	-23.45%	-38.19%	-34.31%	-33.13%	-30.93%

TAI INTERVENTIONS – RETRODUR OUTCOMES

THERAPEUTIC ACADEMIC INTERVENTION (TAI) PROGRAM

OCTOBER 2002 ASSESSMENT SUMMARY

INTERVENTION -- PDL EDUCATION

Number of Recipients Targeted	1695
Number of Prescribers Targeted	337
Method of Intervention	Visit

CONTROL: UTILIZERS ON NON-PDL AGENTS IN THE 574 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Jul 2002 - Sept 2002	$158,193.33	1,903	$83.13	1,040	$50.70	0.61	$0.00	0	$158,193.33	1,903
Post	Nov 2002 - Jan 2003	$92,411.13	759	$121.75	339	$90.87	0.75	$15,314.77	113	$106,523.41	113
	Difference	-$65,782.20	-1,144	$38.63	-701	$40.16	0.14	$15,314.77	113	-$51,669.92	-1,790
	% Change	-41.58%	-60.12%	46.46%	-67.40%	79.21%	22.36%	N/A	N/A	-32.66%	-94.06%

INTERVENTION: TARGETED UTILIZERS ON NON-PDL AGENTS 317 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Jul 2002 - Sept 2002	$204,394.37	1,838	$111.20	1,088	$62.62	0.56	$0.00	0	$204,394.37	1,838
Post	Nov 2002 - Jan 2003	$108,058.18	797	$135.58	357	$100.89	0.74	$0.00	0	$108,058.18	797
	Difference	-$96,336.19	-1,041	$24.38	-731	$38.27	0.18	$0.00	0	-$96,336.19	-1,041
	% Change	-47.13%	-56.64%	21.92%	-67.19%	61.12%	32.15%	0.00%	0.00%	-47.13%	-56.64%

DECEMBER 2002 ASSESSMENT SUMMARY

INTERVENTION -- PDL EDUCATION

Number of Recipients Targeted	1594
Number of Prescribers Targeted	302
Method of Intervention	Visit

CONTROL: UTILIZERS ON NON-PDL PHASE 3 AGENTS IN THE 574 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	July - September 2002	$57,074.16	1,345	$42.43	766	$24.84	0.59	$0.00	0	$57,074.16	1,345
Post	January - March 2003	$5,432.51	113	$48.08	54	$33.53	0.70	$0.00	0	$5,432.51	113
	Difference	-$51,641.65	-1,232	$5.64	-712	$8.70	0.11	$0.00	0	-$51,641.65	-1,232
	% Change	-90.48%	-91.60%	13.29%	-92.95%	35.02%	19.18%	0.00%	0.00%	-90.48%	-91.60%

INTERVENTION: TARGETED UTILIZERS ON NON-PDL PHASE 3 AGENTS IN THE 317 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	July - September 2002	$44,503.44	1,100	$40.46	644	$23.03	0.57	$0.00	0	$44,503.44	1,100
Post	January - March 2003	$3,848.65	86	$44.75	51	$25.15	0.56	$0.00	0	$3,848.65	86
	Difference	-$40,654.79	-1,014	$4.29	-593	$2.12	-0.01	$0.00	0	-$40,654.79	-1,014
	% Change	-91.35%	-92.18%	10.61%	-92.08%	9.20%	-1.28%	0.00%	0.00%	-91.35%	-92.18%

PAGE 2 **TAI INTERVENTION - OUTCOMES**

"-- continued--" THERAPEUTIC ACADEMIC DETAILING INTERVENTION (TAI) PROGRAM

FEBRUARY 2003 ASSESSMENT SUMMARY

INTERVENTION -- PDL EDUCATION

Number of Recipients Targeted	12,769
Number of Prescribers Targeted	652
Method of Intervention	Visit

CONTROL: PRESCRIBER UTILIZATION OF NON-PDL AGENTS IN THE 574 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Nov 2002 - Jan 2003	$370,358.40	11,598	$31.93	4,173	$29.58	0.93	$200,645.03	9,408	$169,713.37	2,190
Post	Mar 2003 - May 2003	$281,280.09	10,636	$26.45	3,962	$23.66	0.89	$174,332.58	9,300	$106,947.51	1,336
	Difference	-$89,078.31	-962	-$5.49	-211	-$5.92	-0.03	-$26,312.45	-108	-$62,765.86	-854
	% Change	-24.05%	-8.29%	-17.18%	-5.06%	-20.01%	-3.41%	-13.11%	-1.15%	-36.98%	-39.00%

INTERVENTION: TARGETED PRESCRIBER UTILIZATION OF NON-PDL AGENTS IN THE 812 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Nov 2002 - Jan 2003	$990,346.94	31,447	$31.49	12,769	$25.85	0.82	$454,148.40	24,687	$536,198.54	6,761
Post	Mar 2003 - May 2003	$726,119.75	29,511	$24.61	12,157	$19.91	0.81	$425,822.69	25,323	$300,297.06	4,188
	Difference	-$264,227.19	-1,936	-$6.89	-612	-$5.94	-0.01	-$28,325.71	636	-$235,901.48	-2,573
	% Change	-26.68%	-6.16%	-21.87%	-4.79%	-22.99%	-1.43%	-6.24%	2.58%	-44.00%	-38.06%

MARCH 2003 ASSESSMENT SUMMARY

INTERVENTION -- PDL EDUCATION

Number of Recipients Targeted	4,685
Number of Prescribers Targeted	505
Method of Intervention	VISIT

CONTROL: PRESCRIBERS IN 574 AREA CODE UTILIZATION OF NON-PDL AGENTS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Dec 2002 - Feb 2003	$327,833.97	11,141	$29.43	4,182	$26.13	0.89	$202,821.12	9,427	$125,012.85	1,714
Post	Apr 2003 - June 2003	$279,648.33	10,635	$26.30	3,922	$23.51	0.90	$170,965.38	9,349	$108,682.95	1,286
	Difference	-$48,185.64	-506	-$3.13	-260	-$2.62	0.02	-$31,855.74	-78	-$16,329.90	-428
	% Change	-14.70%	-4.54%	-10.64%	-6.22%	-10.03%	1.79%	-15.71%	-0.83%	-13.06%	-24.97%

INTERVENTION: TARGETED PRESCRIBERS IN 812 AREA CODE UTILIZATION OF NON-PDL AGENTS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Dec 2002 - Feb 2003	$360,077.90	12,334	$29.19	4,685	$25.62	0.88	$221,839.66	10,345	$138,238.24	1,989
Post	Apr 2003 - June 2003	$302,782.85	12,204	$24.81	4,420	$22.59	0.92	$195,837.56	10,755	$106,945.29	1,449
	Difference	-$57,295.05	-130	-$4.38	-265	-$3.03	0.04	-$26,002.10	410	-$31,292.95	-540
	% Change	-15.91%	-1.05%	-15.02%	-5.66%	-11.84%	4.88%	-11.72%	3.96%	-22.64%	-27.15%

PAGE 3 **TAI INTERVENTION - OUTCOMES**

"-- continued--" THERAPEUTIC ACADEMIC DETAILING INTERVENTION (TAI) PROGRAM

APRIL 2003 ASSESSMENT SUMMARY

INTERVENTION -- PDL EDUCATION

Number of Recipients Targeted	4,053
Number of Prescribers Targeted	510
Method of Intervention	Visit

CONTROL: PRESCRIBERS IN 219 AREA CODE UTILIZATION OF NON-PDL AGENTS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Jan 03 - March 03	$330,627.98	12,236	$27.02	4,668	$23.61	0.87	$221,270.63	10,560	$109,357.35	1,676
Post	May 03 - July 03	$299,650.28	12,084	$24.80	4,378	$22.32	0.92	$196,972.59	10,814	$102,677.69	1,270
	Difference	-$30,977.70	-152	-$2.22	-290	-$1.29	0.05	-$24,298.04	254	-$6,679.66	-406
	% Change	-9.37%	-1.24%	-8.23%	-6.21%	-5.48%	5.30%	-10.98%	2.41%	-6.11%	-24.22%

INTERVENTION: TARGETED PRESCRIBERS IN 317 AREA CODE UTILIZATION OF NON-PDL AGENTS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Cnt
Pre	Jan 03 - March 03	$294,557.36	9,970	$29.54	4,053	$24.23	0.82	$180,457.79	8,754	$114,099.57	1,217
Post	May 03 - July 03	$271,666.86	9,769	$27.81	4,032	$21.97	0.81	$159,103.77	8,580	$112,563.09	1,192
	Difference	-$22,890.50	-201	-$1.74	-21	-$2.26	-0.01	-$21,354.02	-174	-$1,536.48	-25
	% Change	-7.77%	-2.02%	-5.87%	-0.52%	-9.32%	-1.51%	-11.83%	-1.99%	-1.35%	-2.05%

MAY 2003 ASSESSMENT SUMMARY

INTERVENTION -- PDL EDUCATION

Number of Recipients Targeted	4041
Number of Prescribers Targeted	509
Method of Intervention	Visit

CONTROL: ALL UTILIZERS ON NON-PDL DRUGS WITH PRESCRIBERS IN 260 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Feb 2003 - Mar 2003	$415,650.31	14,966	$27.77	5,923	$23.39	0.84	$247,157.32	12,730	$168,492.99	2,236
Post	June 2003 - Aug 2003	$373,671.47	14,514	$25.75	5,428	$22.95	0.89	$226,757.21	12,527	$146,914.26	1,987
	Difference	-$41,978.84	-452	-$2.03	-495	-$0.44	0.05	-$20,400.11	-203	-$21,578.73	-249
	% Change	-10.10%	-3.02%	-7.30%	-8.36%	-1.90%	5.82%	-8.25%	-1.59%	-12.81%	-11.14%

INTERVENTION: TARGETED UTILIZERS ON NON-PDL DRUGS WITH PRESCRIBERS IN 317 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Feb 2003 - Mar 2003	$277,222.75	9,550	$29.03	4,035	$22.90	0.79	$164,068.93	8,370	$113,153.82	1,181
Post	June 2003 - Aug 2003	$262,162.18	9,625	$27.24	4,041	$21.63	0.79	$159,332.75	8,472	$102,829.43	1,157
	Difference	-$15,060.57	75	-$1.79	6	-$1.28	0.01	-$4,736.18	102	-$10,324.39	-24
	% Change	-5.43%	0.79%	-6.17%	0.15%	-5.57%	0.64%	-2.89%	1.22%	-9.12%	-2.03%

PAGE 4 **TAI INTERVENTION - OUTCOMES**

"-- continued--" THERAPEUTIC ACADEMIC DETAILING INTERVENTION (TAI) PROGRAM

JUNE 2003 ASSESSMENT SUMMARY

INTERVENTION -- PDL EDUCATION

Number of Recipients Targeted	7048
Number of Prescribers Targeted	725
Method of Intervention	Visit

CONTROL: UTILIZERS ON NON-PDL DRUGS WITH PRESCRIBERS IN 260 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Mar 2003 - May 2003	$558,623.79	18,791	$29.73	5,673	$32.82	1.10	$291,360.39	15,557	$267,263.40	3,234
Post	Jul 2003 - Sept 2003	$550,749.35	19,136	$28.78	5,824	$31.52	1.10	$308,662.42	16,458	$242,086.93	2,680
	Difference	-$7,874.44	345	-$0.95	151	-$1.30	-0.01	$17,302.03	901	-$25,176.47	-554
	% Change	-1.41%	1.84%	-3.19%	2.66%	-3.97%	-0.80%	5.94%	5.79%	-9.42%	-17.13%

INTERVENTION: TARGETED UTILIZERS ON NON-PDL DRUGS WITH PRESCRIBERS IN 317 AREA CODE

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Mar 2003 - May 2003	$720,120.86	19,428	$37.07	7,048	$34.06	0.92	$307,341.78	16,014	$412,779.08	3,419
Post	Jul 2003 - Sept 2003	$680,037.87	19,166	$35.48	7,106	$31.90	0.90	$323,880.87	16,304	$356,157.00	2,867
	Difference	-$40,082.99	-262	-$1.58	58	-$2.16	-0.02	$16,539.09	290	-$56,622.08	-552
	% Change	-5.57%	-1.35%	-4.28%	0.82%	-6.34%	-2.15%	5.38%	1.81%	-13.72%	-16.15%

JULY 2003 ASSESSMENT SUMMARY

INTERVENTION -SSRI Dose Optimization

Number of Recipients Targeted	189
Number of Prescribers Targeted	30
Method of Intervention	Visit

CONTROL: ALL UTILIZERS PRESCRIPTIONS FILLED FROM CONTROL PRESCRIBERS for SSRI dose optimization

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Apr 2003 - Jun 2003	$207,920.01	1,809	$114.94	816	$84.93	0.74	$62,806.72	834	$145,113.29	975
Post	Aug 2003 - Sept 2003	$182,061.92	1,656	$109.94	769	$78.92	0.72	$55,493.77	800	$126,568.15	856
	Difference	-$25,858.09	-153	-$5.00	-47	-$6.02	-0.02	-7312.950	-34	-$18,545.14	-119
	% Change	-12.44%	-8.46%	-4.35%	-5.76%	-7.08%	-2.86%	-11.64%	-4.08%	-12.78%	-12.21%

INTERVENTION: ALL UTILIZERS PRESCRIPTIONS FILLED FROM TARGETED PRESCRIBERS for SSRI dose optimization

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Apr 2003 - Jun 2003	$49,896.97	425	$117.40	188	$88.47	0.75	$15,788.06	177	$34,108.91	248
Post	Aug 2003 - Sept 2003	$45,298.68	401	$112.96	189	$79.89	0.71	$11,607.45	157	$33,691.23	244
	Difference	-$4,598.29	-24	-$4.44	1	-$8.58	-0.05	-$4,180.61	-20	-$417.68	-4
	% Change	-9.22%	-5.65%	-3.78%	0.53%	-9.70%	-6.15%	-26.48%	-11.30%	-1.22%	-1.61%

PAGE 5 **TAI INTERVENTION - OUTCOMES**

"-- continued--" THERAPEUTIC ACADEMIC DETAILING INTERVENTION (TAI) PROGRAM

AUGUST 2003 ASSESSMENT SUMMARY

INTERVENTION -- Dose Optimization of SSRI's

Number of Utilizers Targeted	103
Number of Prescribers Targeted	60
Number of Prescribers Visited	24
Method of Intervention	Visit

CONTROL: UTILIZERS ON SSRIs, MORE THAN ONE DOSE DAILY, HIGHEST STRENGTHS EXCLUDED.

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	May 2003 - July 2003	$130,023.38	951	$136.72	822	$52.73	0.39	$33,123.69	407	$96,899.69	544
Post	Sept 2003 - Nov 2003	$105,575.50	840	$125.69	729	$48.27	0.38	$35,420.18	427	$70,155.32	413
	Difference	-$24,447.88	-111	-$11.04	-93	-$4.45	0.00	$2,296.49	-20	-$26,744.37	-131
	% Change	-18.80%	-11.67%	-8.07%	-11.31%	-8.44%	-0.40%	6.93%	4.91%	-27.60%	-24.08%

INTERVENTION: TARGETED UTILIZERS ON, MORE THAN ONE DOSE DAILY, HIGHEST STRENGTHS EXCLUDED.

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	May 2003 - July 2003	$18,189.82	159	$114.40	101	$60.03	0.52	$4,723.84	69	$13,465.98	90
Post	Sept 2003 - Nov 2003	$15,288.27	169	$90.46	103	$49.48	0.55	$3,969.82	85	$11,318.45	84
	Difference	-$2,901.55	10	-$23.94	2	-$10.56	0.02	-$754.02	16	-$2,147.53	-6
	% Change	-15.95%	6.29%	-20.92%	1.98%	-17.58%	4.23%	-15.96%	23.19%	-15.95%	-6.67%

SEPTEMBER 2003 ASSESSMENT SUMMARY

INTERVENTION 1-- High Utilizers Targeted for PDL Education

Number of Recipients Targeted	488
Number of Prescribers Targeted	60
Method of Intervention	Visit

CONTROL: HIGH PRESCRIBERS BASED ON DOLLARS SPENT PER UTILIZER PER MONTH

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Jun 2003 - Aug 2003	$884,563.56	20,580	$42.98	293	$1,006.33	23.41	$176,467.15	12,001	$708,096.41	8,604
Post	Oct 2003 - Dec 2003	$680,578.90	15,773	$43.15	268	$846.49	19.62	$119,753.95	9,220	$560,824.95	6,567
	Difference	-$203,984.66	-4,807	$0.17	-25	-$159.84	-3.79	-$56,713.20	-2,781	-$147,271.46	-2,037
	% Change	-23.06%	-23.36%	0.39%	-8.53%	-15.88%	-16.21%	-32.14%	-23.17%	-20.80%	-23.68%

INTERVENTION: TARGETED PRESCRIBERS BASED ON DOLLARS SPENT PER UTILIZER PER MONTH

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count	Brand Amount Paid	Brand Rx Count
Pre	Jun 2003 - Aug 2003	$1,771,920.60	39,719	$44.61	488	$1,210.33	27.13	$335,563.64	22,720	$1,436,356.94	17,250
Post	Oct 2003 - Dec 2003	$1,154,880.90	26,304	$43.91	428	$899.44	20.49	$203,507.23	15,206	$951,373.67	11,204
	Difference	-$617,039.70	-13,415	-$0.71	-60	-$310.89	-6.64	-$132,056.41	-7,514	-$484,983.27	-6,046
	% Change	-34.82%	-33.77%	-1.58%	-12.30%	-25.69%	-24.49%	-39.35%	-33.07%	-33.76%	-35.05%

RETRODUR LETTER INTERVENTION - OUTCOMES

JANUARY 2003 ASSESSMENT SUMMARY

INTERVENTION TYPE -- Underutilization of Long-Term Controller Medications in Asthmatics

Number of Recipients Targeted	862
Number of Letters Mailed	764
Number of Prescribers Targeted	495
Number of Letters Returned	159
Percent Letter Returned	20.82%
Method of Intervention	Mailing

CONTROL: ALL UTILIZERS ON ALBUTEROL INHALERS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count
Pre	Oct 2002 - Dec 2002	$23,558.54	1580	$14.91	538	$14.60	0.98	$23,558.54	1580
Post	Feb 2003 - Apr 2003	$16,764.68	1198	$13.99	460	$12.15	0.87	$16,764.68	1198
	Difference	-$6,793.86	-382	-$0.92	-78	-$2.45	-0.11	-$6,793.86	-382
	% Change	-28.84%	-24.18%	-6.15%	-14.50%	-16.77%	-11.32%	-28.84%	-24.18%

INTERVENTION: TARGETED UTILIZERS ON ALBUTEROL INHALERS

Intervention Period	Intervention Dates	Amount Paid	# RX	Amount Paid per Rx	# Recipients (Unique)	PUPM (per utilizer per month)	# Rx per Unique Recip per Month	Generic Amount Paid	Generic RX Count
Pre	Oct 2002 - Dec 2002	$5,069.72	334	$15.18	122	$13.85	0.91	$5,069.72	334
Post	Feb 2003 - Apr 2003	$3,457.05	251	$13.77	107	$10.77	0.78	$3,457.05	251
	Difference	-$1,612.67	-83	-$1.41	-15	-$3.08	-0.13	-$1,612.67	-83
	% Change	-31.81%	-24.85%	-9.26%	-12.30%	-22.25%	-14.32%	-31.81%	-24.85%

SAVINGS ANALYSIS - FFY 2003

All RetroDUR Programs

MONTH / YEAR	NAME OF INITIATIVE	PROGRAM TYPE	# PTS REVIEWED	# PTS INTERVENED	# PRESCRIBERS TARGETED	CONVERSION RATE	CHANGE $PUPM CONTROL	CHANGE $PUPM TARGET	$ SAVED PUPM	# PTS CONVERTED	INTERVENTION MONTH SAVINGS	PROJECTED ANNUAL SAVINGS	PROJECTED SAVINGS $PUPYear
October-02	PDL ACEI ED	IBM	1,610	1,586	685	93.0%	$2.88	($6.64)	$9.52	1469	$13,984.88	$167,818.56	$114.24
November-02	PDL THIAZOLIDINEDIONES ED	IBM	1,514	1,470	736	83.3%	($64.58)	($82.09)	$17.51	1222	$21,397.22	$256,766.64	$210.12
December-02	PDL ARB ED	IBM	1,739	1,686	912	76.3%	($17.67)	($23.63)	$5.96	1155	$6,883.80	$82,605.60	$71.52
January-03	PDL SERMS	IBM	1,313	1,302	588	54.5%	($23.46)	($20.73)	($2.73)	703	($1,919.19)	($23,030.28)	($32.76)
February-03	PDL SERMS	IBM	1,516	0	644	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
March-03	NO INTERVENTION APPROVED	IBM	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
April-03	NO INTERVENTION APPROVED	IBM	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
May-03	NO INTERVENTION APPROVED	IBM	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
June-03	NO INTERVENTION APPROVED	IBM	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
July-03	DOSE OP SSRIs	IBM	1,072	1,058	759	58.2%	($13.18)	($9.07)	($4.11)	669	($2,749.59)	($32,995.08)	($49.32)
August-03	NO INTERVENTION APPROVED	IBM	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
September-03	HIGH UTILIZER PDL ED	IBM	4,377	501	756	87.4%	($153.49)	($298.06)	$144.57	438	$63,321.66	$759,859.92	$1,734.84
TOTALS			13,141	7,603	5,080						$100,918.78	$1,211,025.36	$2,048.64

MONTH/YEAR	NAME OF INITIATIVE	PROGRAM TYPE	# PTS REVIEWED	# PTS INTERVENED	# PRESCRIBERS TARGETED	CONVERSION RATE	CHANGE $PUPM CONTROL	CHANGE $PUPM TARGET	$ SAVED PUPM	# PTS CONVERTED	INTERVENTION MONTH SAVINGS	PROJECTED ANNUAL SAVINGS	PROJECTED SAVINGS $PUPYear
October-02	PDL ED	TAI	1,695	1,695	337	43.1%	$40.16	$38.27	$1.89	731	$1,381.59	$16,579.08	$22.68
November-02	NO INTERVENTION APPROVED	TAI	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
December-02	PDL ED	TAI	1,594	1,594	302	37.2%	$8.70	$2.12	$6.58	593	$3,901.94	$46,823.28	$78.96
January-03	NO INTERVENTION APPROVED	TAI	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
February-03	PDL ED	TAI	12,769	12,769	652	95.2%	($5.92)	($5.94)	$0.02	12157	$243.14	$2,917.68	$0.24
March-03	PDL ED	TAI	4,685	4,685	505	94.3%	($2.62)	($3.03)	$0.41	4420	$1,812.20	$21,746.40	$4.92
April-03	PDL ED	TAI	4,053	4,053	510	99.4%	($1.29)	($2.26)	$0.97	4032	$3,911.04	$46,932.48	$11.64
May-03	PDL ED	TAI	4,035	4,035	509	100.1%	($0.44)	($1.28)	$0.84	4041	$3,394.44	$40,733.28	$10.08
June-03	PDL ED	TAI	7,048	7,106	725	100.8%	($1.30)	($2.16)	$0.86	7106	$6,111.16	$73,333.92	$10.32
July-03	DOSE OP SSRIs	TAI	188	189	30	5.9%	($6.02)	($8.58)	$2.56	189	$483.84	$5,806.08	$30.72
August-03	DOSE OP SSRIs	TAI	101	103	24	6.3%	($4.45)	($10.56)	$6.11	103	$629.33	$7,551.96	$73.32
September-03	HIGH UTILIZER PDL ED	TAI	488	488	60	33.8%	($159.84)	($310.89)	$151.05	428	$64,649.40	$775,792.80	$1,812.60
TOTALS			36,656	36,717	3,654						$86,518.08	$1,038,216.96	$2,055.48

MONTH/YEAR	NAME OF INITIATIVE	PROGRAM TYPE	# PTS REVIEWED	# PTS INTERVENED	# PRESCRIBERS TARGETED	CONVERSION RATE	CHANGE $PUPM CONTROL	CHANGE $PUPM TARGET	$ SAVED PUPM	# PTS CONVERTED	INTERVENTION MONTH SAVINGS	PROJECTED ANNUAL SAVINGS	PROJECTED SAVINGS $PUPYear
October-02	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
November-02	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
December-02	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
January-03	ALBUTEROL OVERUT IN ASTHMA	RetroDUR	862	764	495	20.8%	($2.45)	($3.08)	$0.63	107	$67.41	$808.92	$7.56
February-03	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
March-03	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
April-03	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
May-03	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
June-03	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
July-03	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
August-03	NO INTERVENTION APPROVED	RetroDUR	0	0	0	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
September-03	LIPOTROPIC DOSE OP	RetroDUR	19,741	247	226	0.0%	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00
TOTALS			20,603	1,011	721						$67.41	$808.92	$7.56

ENTIRE RETRO-DUR PROGRAM COMBINED	# PTS REVIEWED	# PTS INTERVENED	# PRESCRIBERS TARGETED	INTERVENTION MONTH SAVINGS	PROJECTED ANNUAL SAVINGS	PROJECTED SAVINGS $PUPYear
	70,400	45,331	9,455	$187,504.27	$2,250,051.24	$1,370.56

ATTACHMENT 6.2
IRDP Prior Authorization Evaluation: THE MEDSTAT GROUP STUDIES

Indiana Medicaid DUR Board Report

Indiana Rational Drug Program (IRDP) Evaluation

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) and
COX-2 Inhibitors

Presented November 15, 2002

Prepared by the Office of Medicaid Policy & Planning and
The Medstat Group

Indiana Medicaid DUR Board Report
Indiana Rational Drug Program (IRDP) Evaluation
Nonsteroidal Anti-Inflammatory Drugs (NSAID) and COX-2 Inhibitors

Introduction

A. Objectives

The Indiana Medicaid Drug Utilization Review Board requested that the Office of Medicaid Policy and Planning (OMPP) develop and produce reports to evaluate the impact of the Indiana Rational Drug Program (IRDP). The program, requiring prior authorization for specific classes of drugs, was implemented on January 7, 2002.

The evaluation has two primary objectives. One objective is to use retrospective, paid claims data to analyze the impact of the IRDP on prescribing patterns, Medicaid drug expenditures, and drug utilization. In order to evaluate impact, information regarding NSAID/COX-2 Inhibitor prescriptions and recipients of the prescriptions prior to January 7, 2002 will be reported. These data are referred to as "baseline" because the events occurred prior to implementation of the IRDP.

The second objective is to use retrospective, paid claims data, to the extent possible, to evaluate recipient outcomes that may be related to implementation of the IRDP. The selected outcomes measures are the rates of physician office visits (excluding preventive care), inpatient admissions and emergency room visits following receipt of a prescription for a Brand Name NSAID or COX-2 Inhibitor. Outcomes are evaluated for all recipients of the drugs and further evaluated for persons with and without prior authorization (PA). Medicaid eligible persons who received a prior authorization denial were also evaluated based on whether or not a substitute medication was prescribed and dispensed.

B. Methodology

The data source is the Medstat DataProbe® Decision Support System Indiana Medicaid paid claims database. The data include pharmacy and medical services claims for Medicaid covered services that were paid through June 30, 2002. Prior Authorization data is provided in the extracts transmitted to Medstat from EDS.

A study design was prepared by OMPP and The Medstat Group (Medstat) and presented to the DUR Board for review and approval. At the April 2002 DUR Board meeting, the Board approved the study and agreed that the preliminary findings should be focused on Brand Name Nonsteroidal Anti-inflammatory Drugs (NSAIDs) and COX-2 Inhibitors. NSAIDs/COX-2 Inhibitors were selected because this prior authorization program was the first to be implemented under t
he IRDP and will provide the largest volume of data in the short term. It was also decided that the preliminary report would include "baseline" information regarding NSAIDs/COX-2 Inhibitor prescriptions from the year prior to implementation of the program.

1. Drug Claims Data

The first portion of the analysis includes the following baseline information regarding Brand Name NSAID and COX-2 Inhibitor drugs prescribed during Calendar Year 2001. These data are considered baseline as they reflect prescription experience prior to implementation of the IRDP:

- Number of Medicaid Eligible Persons under age 70
- Number of Prescriptions
- Expenditures for Prescriptions
- Unique Number of Recipients
- Payments per Prescription
- Payments per Recipient
- Prescriptions per 1000 Eligible Persons

The above measures are categorized by Aid Category, Gender, Age Group, Region of Residence and Totals.

The fields "FDB drug innovator code" and "FDB drug source code" were used to identify brand name drugs. According to EDS, these fields are the most appropriate indicator of generic versus brand designation.

These data were produced using paid claims data for the entire calendar year 2001 and also for just the first six months of calendar year 2001. Data was produced on the first six months of 2001 so that comparisons can be made to the available data for calendar year 2002. At the time the reports were produced, the DataProbe database was updated with claims paid through June 30, 2002.

Each of the measures described above were also produced for prescriptions incurred from January 7, 2002 through June 30, 2002. It is important to note that, due to the lag between claim submission and payment, the incurred data for the last month or more of the time period is incomplete.

2. Outcomes

The DUR Board is interested in the impact that the IRDP may have on quality of care. In order to get a general idea of the utilization trends for people prescribed IRDP drugs, paid claims data for specific medical service are also analyzed. While the health care encounters may not be attributable to conditions involving the drugs, the data provides a general picture of the utilization patterns. Variations in the patterns may raise questions for further investigation.

The health care encounters included in the study are physician office visits (excluding preventive services), inpatient hospital admissions, and emergency room visits. Having identified recipients of Brand Name NSAID/COX-2 Inhibitor prescriptions in the baseline portion of the study, the outcomes reports are produced by linking these recipients to medical claims incurred following the Brand Name NSAID/COX-2 Inhibitor prescription.

The DUR Board is also interested in potential outcomes variations related to prior authorization determinations and subsequent prescribing decisions. Three cohorts were developed for this portion of the study using the prior authorization data in the DataProbe database:
Individuals who had a PA denial and were prescribed a substitute medication (generic source agent).
Individuals who had a PA denial and were not prescribed a substitute medication.
Individuals who had PA approval and were prescribed the medication.

Organization of Report

Because the IRDP was implemented on January 7, 2002, the data are organized by the calendar year in which prior authorization was requested and/or drug claims were paid.

The first section of this report provides an overview of the baseline information regarding Brand Name NSAID/COX-2 Inhibitor utilization, including year-to-year comparisons. The second section provides an overview of the health care experience of recipients following a Brand Name NSAID/COX-2 Inhibitor prescription. Attachment A includes the detailed data from which the summaries were drawn. The final section of this report describes the findings related to the three cohorts of Medicaid eligible persons described above.

II. Results: Baseline NSAID/COX-2 Inhibitor Prescription Data

Detailed Results: Calendar Year 2001 (CY01)

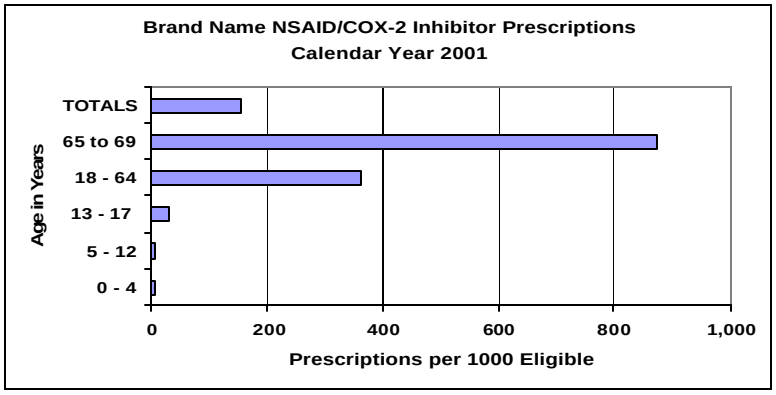
In CY01, Brand Name NSAIDs/COX-2 Inhibitors were prescribed at a rate of 154 prescriptions per thousand Medicaid eligible persons and 5% of all eligible persons received a prescription. The net payment for the drugs was $8,231,556 with an average net cost of $75 per prescription and $256 per recipient.

Fifty-eight percent of the recipients were female and 42% were male. Women were prescribed Brand Name NSAIDs/COX-2 Inhibitors at a rate of 197 prescriptions per 1000 eligible as compared to a rate of 96 per thousand for men.

1. Age Group Information

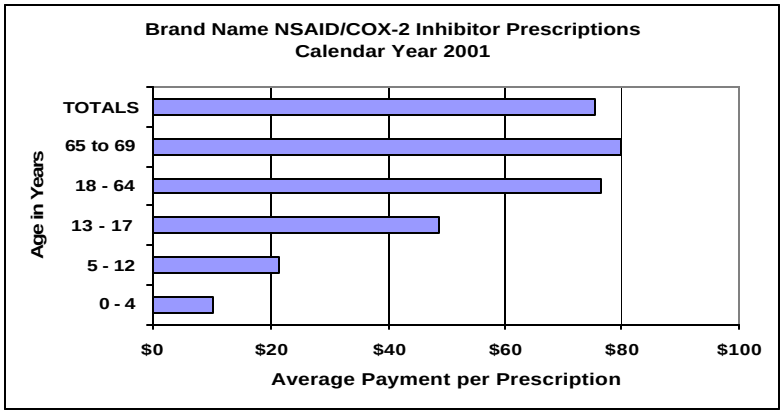
Prescriptions per 1000 Eligibles

Brand Name NSAID/COX-2 Inhibitor recipients aged 65 to 69 years received the highest number of prescriptions per capita at 873 per thousand eligible individuals. Children aged 0 to 4 years received the lowest number of prescriptions at 4 per thousand eligible individuals.



Payments per Brand Name NSAID/COX-2 Inhibitor Prescription

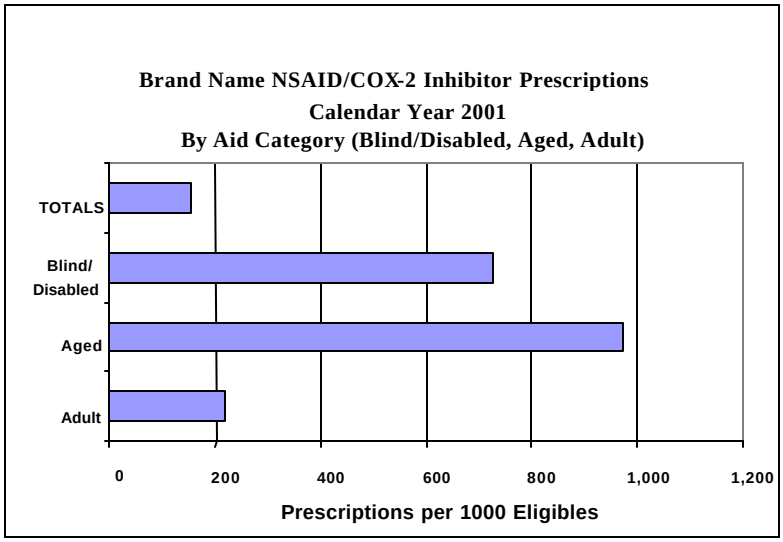
The average payment per prescription was $75. Adults aged 65 to 69 had the highest payments per prescription ($80) and payments per recipient ($348). The lowest payments per prescription were made for children under age 5 at $10. Children had a high proportion of prescriptions for Brand Name NSAIDs while the older population had a higher percentage of COX-2 Inhibitors which are more costly per prescription.



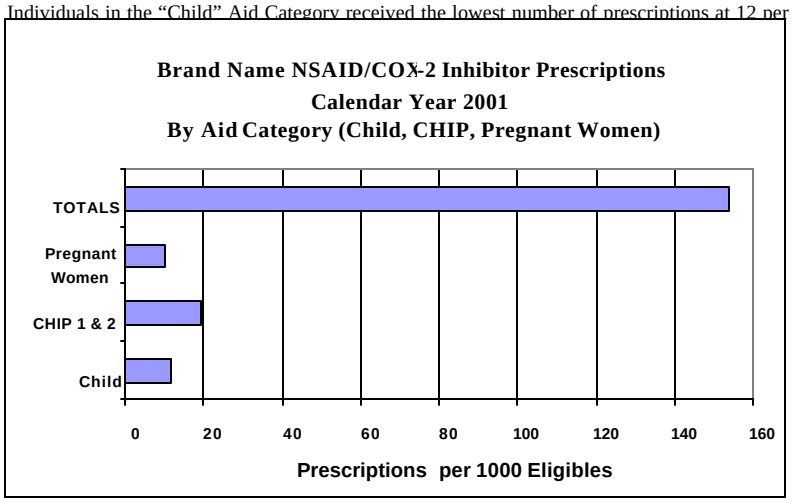
Aid Category Information

Aid Category Information was not present on all paid claims records. An additional category titled “Missing Aid Category” was included for completeness when calculating totals. However, because the claims with "missing" values are not analytically useful, these data are not presented on the graphs.

Recipients in the Aged and Blind/Disabled aid categories received the highest number of prescriptions at 976 and 725 per thousand eligible persons respectively.



Individuals in the "Child" Aid Category received the lowest number of prescriptions at 12 per 1000 eligible persons.



Region of Residence Information

Residents of the South Region received the highest rate of prescriptions at 216 per thousand although the highest percentage of recipients lived in the Central Region (38%). Payments per prescription and per recipient were highest in the Central Region.

Region of Residence	Percent of Total NSAID/Cox-2 Recipients	Payments per Prescription	Payments per Recipient	Prescriptions per 1000 Eligibles
Central	38%	$74	$233	141
North	28%	$76	$275	124

South	35%	$76	$265	216
TOTALS	100%	$75	$256	154

B. Comparison Results: Baseline Calendar Year 2001 (CY01) to Post-intervention Calendar Year 2002 (CY02)

1. Brief Summary of Results

There was a sizeable decrease in the rate of prescriptions per eligible for Brand Name NSAIDs/COX-2 Inhibitors following implementation of the Indiana Rational Drug Program (IRDP)

There was an increase in the amount Medicaid paid per Brand Name NSAID/COX-2 Inhibitor following implementation of the IRDP.

There was a sizeable decrease in the total net payments for Brand Name NSAIDs/COX-2 Inhibitors following implementation of the IRDP driven by the decrease in prescriptions.

Methodology

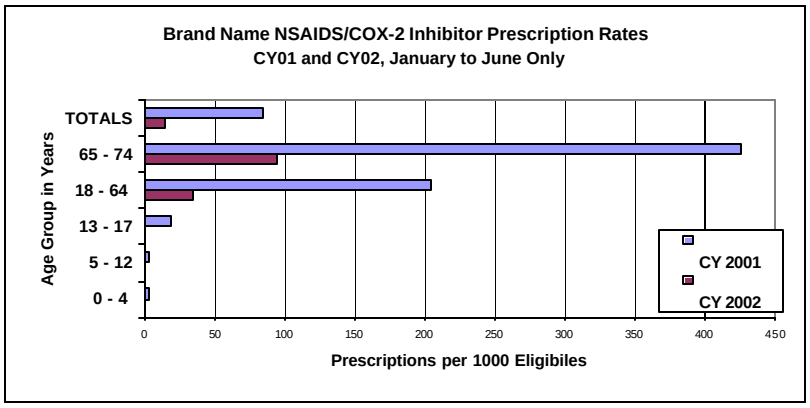
The DataProbe paid claims database currently includes claims paid through June 30, 2002. Therefore, CY02 data is available for prescriptions written and paid between January 1 and June 30, 2002. The database is updated quarterly and the next update will be completed in mid-November 2002.

In order to produce the most valid comparisons between CY01 and CY02, the baseline utilization data were also produced for the January through June period in CY01. It is important to remember that claims for prescriptions written and filled in June of 2002 may not have been paid by June 30, 2002. Therefore, the CY02 data will not be as complete as the data for CY01.

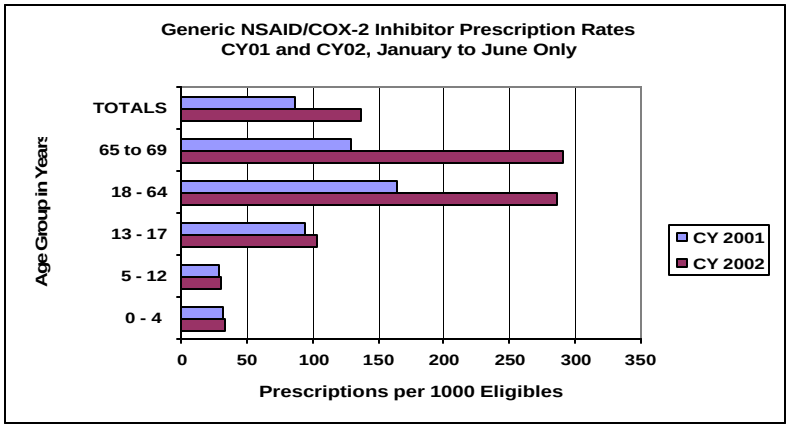
3. Overall Comparisons

Prescription Rates by Age Group:

The number of prescriptions for Brand Name NSAIDs and COX-2 Inhibitors was 14 per thousand eligible persons in the first 6 months of CY02 compared to 84 per thousand during the same time period in CY01.

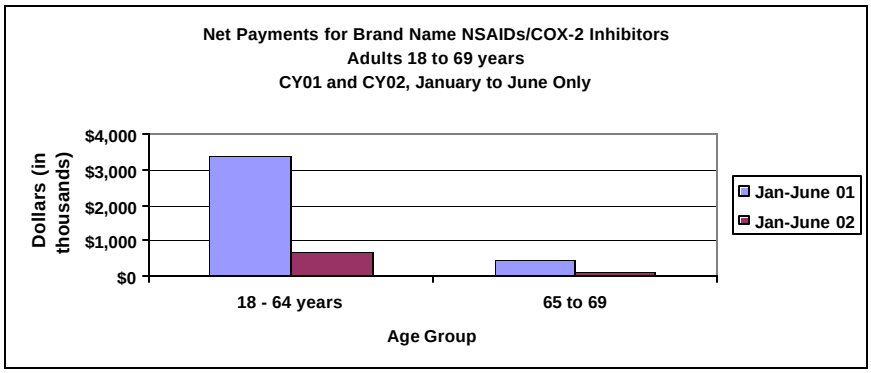


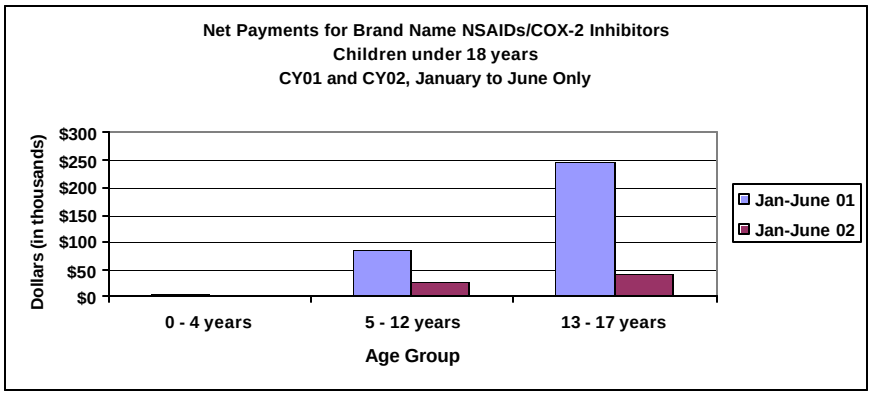
The number of prescriptions for Generic NSAIDs and COX-2 Inhibitors increased across the same time periods.



Total Net Payments for NSAID/COX-2 Inhibitor Prescriptions:

The total net payments for NSAIDs and COX-2 Inhibitors decreased by 80% in the first six months of CY02 as compared to the first six months of CY01. Expenditures were $3.9 million in the first six months of CY01 and $0.8 million in CY02. Net payments decreased for individuals in all age groups.





Deleted: 6/28/04
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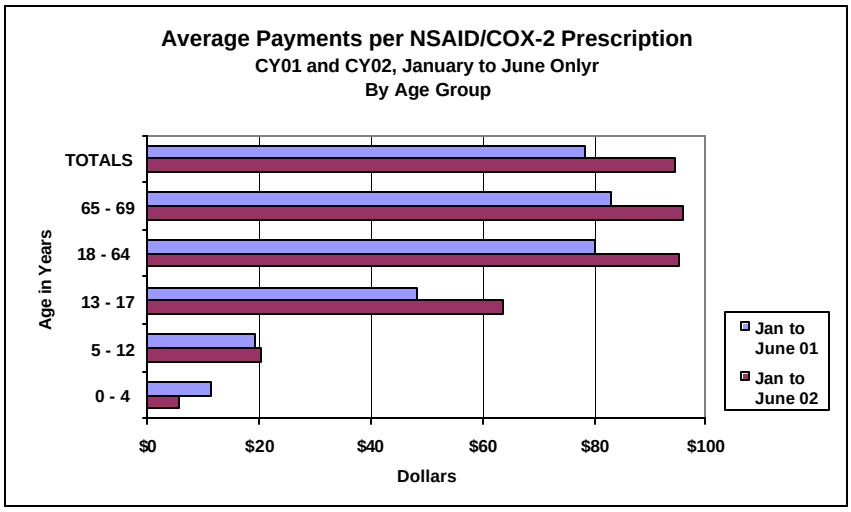
Payments per Prescription:

The average payment per prescription increased across the two time periods. However, the average price per prescription did decrease for children under 5 years of age.



Top Drugs:
In the first 6 months of Calendar Year 2001, top drugs by net payments were as follows:

HICL	Prescriptions	Payments
Celecoxib (CELEBREX)	21,338	$1,910,563
Rofecoxib (VIOXX)	19,469	$1,488,601

In the first 6 months of Calendar Year 2002, top drugs by net payments were as follows:

HICL	Prescriptions	Payments
Celecoxib (CELEBREX)	4,544	$439,987
Rofecoxib (VIOXX)	2,801	$228,636

III. Results: Outcomes Studies

A. Introduction

Reports were produced to identify the number of inpatient admissions, physician office visits and emergency room visits experienced by recipients following a prescription for an NSAID or COX-2 Inhibitor. Baseline reports were produced for the first 6months of CY01. These reports include a measure of the percent of NSAID/COX-2 Inhibitor prescription recipients who received the designated medical treatment within specific periods of time following the initial prescription within the year. The same measures were produced for the post-implementation time period, the first 6 months of CY02.

B. Healthcare Encounters Following Brand Name NSAID/COX-2 Inhibitor Prescriptions

The following chart illustrates the findings for the first 6 months of CY01, prior to implementation of the IRDP.

Chart 1: CY01 Findings

Days Following First NSAID/COX-2 Inhibitor Prescription	Percent of NSAID/COX-2 Inhibitor Recipients with Office Visit Following Prescription	Percent of NSAID/COX-2 Inhibitor Recipients with Admission Following Prescription	Percent of NSAID/COX-2 Inhibitor Recipients with ER Visit Following Prescription
0 - 60	67.44%	2.13%	18.58%
61-120	32.61%	1.23%	8.43%
121 - 180	12.12%	0.28%	2.98%
TOTALS	72.73%	3.45%	24.81%

These rates were calculated based on health care encounters for any reason and may include care that was unrelated to the prescription or to the condition for which the drug was prescribed. The report provides a high level picture of the utilization of these services for patients who previously had prescriptions for NSAIDs or COX-2 Inhibitors.

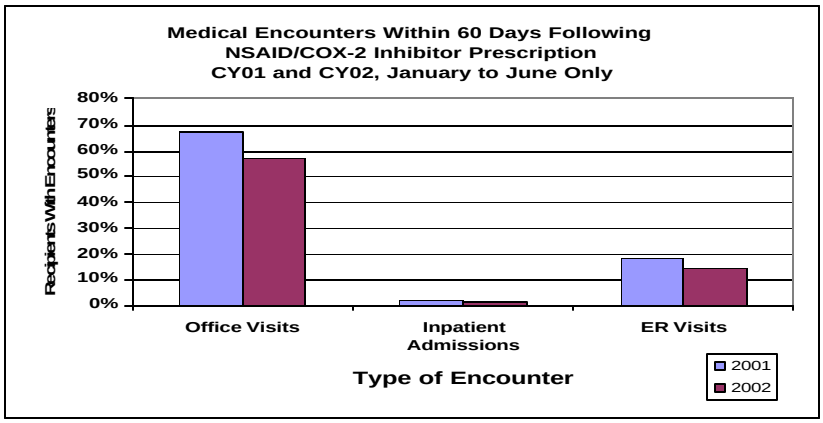
The next chart illustrates the findings for CY02 (January 7 to June 30, 2002) obtained from the database that includes claims paid through June 30, 2002. These rates were calculated using the same criteria as was used for the CY01 report.

Medicaid medical service claims are often submitted and/or paid more than a month following the date of service or hospital discharge. Therefore, the data for CY02 is not as complete as the data for CY01. This means that there may be additional healthcare encounters for the CY02 recipients that are not reported in the data. The healthcare encounter data for CY02 is approximately 90% complete in this report.

Chart 2: CY02 Findings (January to June)

Days Following First NSAID/COX-2 Inhibitor Prescription	Percent of NSAID/COX-2 Inhibitor Recipients with Office Visit Following Prescription	Percent of NSAID/COX-2 Inhibitor Recipients with Admission Following Prescription	Percent of NSAID/COX-2 Inhibitor Recipients with ER Visit Following Prescription
0 - 60	57.24%	1.85%	14.88%
61-120	27.79%	0.76%	6.23%
121 - 180	6.26%	0.00%	1.04%
TOTALS	70.86%	2.61%	18.28%

The following graph illustrates the year to year comparison for each type of healthcare encounter. The first 60 days following a prescription was selected as these data are most apt to be complete for Calendar Year 2002 and allow for appropriate comparison than the totals.



C. Outcomes Studies Based on Recipient Cohorts

1. Methodology

An additional component of the evaluation of the IRDP involves development of cohorts of recipients for whom prior authorization requests were made. The cohorts of interest are as follows:

Cohort 1: Recipients who were denied prescriptions under the IRDP Prior Authorization Process and prescribed a formulary medication.
"PA_status" = 'D' (Denied) AND
Prescription for generic NSAID/COX-2 Inhibitor(s)

Cohort 2: Recipients who were denied prescriptions under the IRDP Prior Authorization Process and not prescribed a substitute medication.
'PA_status" = 'D' (Denied) AND
No prescription for NSAID/COX-2 Inhibitor(s)

Cohort 3: Recipients with approved prescriptions under the IRDP Prior Authorization Process.
'PA_status" = 'A' (Approved) AND
Prescription for Brand Name NSAID/COX-2 Inhibitor

EDS provides tables including drug prior authorization program data to Medstat for inclusion in the DataProbe database. The tables are cumulative since the implementation of the IRDP.

2. Results
These reports were produced using the DataProbe paid claims database including Medicaid medical claims paid between January 7, 2002 and June 30, 2002. The Cohorts were defined using Prior Authorization and Paid Drug Claims Data from the same database.

Inpatient Admissions

Cohort	Recipients	No. of Recipients with Inpatient Admissions	% of Cohort with Inpatient Admissions
1 – Denied and Substitute	679	26	4
2 – Denied and No Substitute	625	50	8
3 - Approved	3,562	93	3

Emergency Room Visits

Cohort	Recipients	No. of Recipients with Emergency Room Visits	% of Cohort with Emergency Room Visits
1 – Denied and Substitute	679	204	30
2 – Denied and No Substitute	625	133	21
3 - Approved	3,562	651	18

Physician Office Visits (excludes preventive care)

Cohort	Recipients	No. of Recipients with Office Visits	% of Cohort with Office Visits
1 – Denied and Substitute	679	621	92
2 – Denied and No Substitute	625	500	80
3 - Approved	3,562	2,524	71

Indiana Rational Drug Program Evaluation

Brand Name Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) and COX-2 inhibitors

Indiana Office of Medicaid Policy and Planning

BASELINE DATA

A. Drug Claims Paid for Prescriptions Written in Calendar Year 2001

1. Age Group (in Years)	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients*	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
0 - 4	167,784	700	$7,148	601	$10	$12	4
5 - 12	189,079	851	$18,207	662	$21	$28	5
13 - 17	84,078	2,566	$125,180	1,619	$49	$77	31
18 - 64	253,720	92,319	$7,045,409	26,459	$76	$266	364
65 to 69	14,886	12,999	$1,035,613	2,973	$80	$348	873
TOTALS	709,547	109,435	$8,231,556	32,094	$75	$256	154

2. Gender	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
Female	411,230	80,918	$6,113,150	23,645	$76	$259	197
Male	298,317	28,517	$2,118,405	8,449	$74	$251	96
TOTALS	709,547	109,435	$8,231,556	32,094	$75	$256	154

*The count of unique recipients is unique within each row, including the totals. A recipient may be counted in more than one row if they received prescriptions before and after a birthday.

3. Aid Category	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients*	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
Adult	91,498	19,942	$1,377,750	8,428	$69	$163	218
Aged	12,785	12,476	$996,911	2,873	$80	$347	976
Blind\Disabled	96,933	70,251	$5,567,488	16,861	$79	$330	725
Child	395,688	4,633	$177,160	3,188	$38	$56	12
CHIP 1 & 2 Child	70,459	1,350	$63,225	888	$47	$71	19
Pregnant Women	36,052	369	$13,173	274	$36	$48	10
Missing Aid Category	6,138	414	$35,850	76	$87	$472	67
TOTALS	709,547	109,435	$8,231,556	32,094	$75	$256	154

4. Region of Recipient Residence	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients*	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
Central	272,029	38,420	$2,829,365	12,146	$74	$233	141
North	256,941	31,964	$2,444,973	8,896	$76	$275	124
South	180,577	39,051	$2,957,218	11,178	$76	$265	216
TOTALS	709,547	109,435	$8,231,556	32,094	$75	$256	154

*The count of unique recipients is unique within each row, including the totals. A recipient may be counted in more than one row if they received prescriptions before and after a change in aid category or move across regions.

BASELINE DATA

B. Medical Services Incurred Following Initial Brand Name NSAID/COX-2 Inhibitor Prescription

1. Office Visits Following NSAID/COX-2 Inhibitor Prescription in Calendar Year 2001

Days Following NSAID/COX-2 Inhibitor Prescription	Number of Office Visits	Net Payments for Office Visits	Unique Recipients*	Payment per Visit	Payment per Recipient	% of NSAID/COX-2 Inhibitor Recips with Office Visit Following Prescription
0-60	53,666	$1,217,780	22,243	$23	$55	69%
61-120	33,170	$711,602	14,441	$21	$49	45%
121 - 180	23,335	$510,385	10,697	$22	$48	33%
181 - 240	16,775	$364,850	7,750	$22	$47	24%
241 - 365	12,914	$289,145	5,025	$22	$58	16%
TOTALS	139,860	$3,093,762	25,707	$22	$120	80%

* Recipient may be counted in more than one row because the first prescription for each individual drug (NDC) was counted as an NSAIDS or COX-2 prescription event. The first prescription date for each individual type of drug was calculated for each recipient.

Office visits were then associated with each event.

2. Inpatient Admissions Following NSAID/COX-2 Inhibitor Prescription in Calendar Year 2001

Days Following NSAID/COX-2 Inhibitor Prescription	Number of Admissions	Net Payments	Unique Recipients*	Payment per Admission	Payment per Recipient	% of NSAID/COX-2 Inhibitor Recips with Admission Visit Following Prescription
0-60	735	$813,863	702	$1,107	$1,159	2.19%
61-120	534	$445,492	518	$834	$860	1.61%
121 - 180	432	$394,745	401	$914	$984	1.25%
181 - 240	315	$311,192	298	$988	$1,044	0.93%
241 - 365	238	$183,404	216	$771	$849	0.67%
TOTALS	2,254	$2,148,696	1,838	$953	$1,169	5.73%

* Recipient may be counted in more than one row because the first prescription for each individual drug (NDC) was counted as an NSAIDS or COX-2 prescription event. The first prescription date for each individual type of drug was calculated for each recipient.

Admissions were then associated with each event.

3. Emergency Room (ER) Visits Following NSAID/COX-2 Inhibitor Prescription in Calendar Year 2001

Days Following NSAID/COX-2 Inhibitor Prescription	Number of ER Visits	Net Payments	Unique Recipients*	Payment per ER Visit	Payment per Recipient	% of NSAID/COX-2 Inhibitor Recips with ER Visit Following Prescription
0 - 60	12,486	$1,150,241	7,840	$92	$147	24%
61-120	7,689	$686,612	4,870	$89	$141	15%
121 - 180	5,911	$506,468	3,830	$86	$132	12%
181 - 240	4,038	$339,708	2,609	$84	$130	8%
241 - 365	3,196	$263,501	1,872	$82	$141	6%
TOTALS	33,320	$2,946,531	13,082	$88	$225	41%

* Recipient may be counted in more than one row because the first prescription for each individual drug (NDC) was counted as an NSAIDS or COX-2 prescription event. The first prescription date for each individual type of drug was calculated for each recipient.

Emergency Room Visits were then associated with each event.

Indiana Rational Drug Program Evaluation							
Brand Name Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) and COX-2 inhibitors							
Indiana Office of Medicaid Policy and Planning							
BASELINE DATA							
A. **Drug Claims** Paid for Prescriptions Written January 1 to June 30, 2001							
1. Age Group							
Age Group	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients*	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
0 - 4 years	144,506	416	$4,759	369	$11	$13	3
5 - 12 years	163,240	565	$10,914	463	$19	$24	3
13 - 17 years	70,843	1,383	$66,975	977	$48	$69	20
18 - 64 years	207,587	42,381	$3,397,645	17,313	$80	$196	204
65 to 69	13,692	5,826	$483,104	1,958	$83	$247	426
TOTALS	599,868	50,571	$3,963,396	21,080	$78	$188	84
2. Gender	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
Female	345,539	37,688	$2,963,791	15,696	$79	$189	109
Male	254,329	12,883	$999,605	5,384	$78	$186	51
TOTALS	599,868	50,571	$3,963,396	21,080	$78	$188	84
*The count of unique recipients is unique within each row, including the totals. A recipient may be counted in more than one row if they received prescriptions before and after a birthday.							
3. Aid Category	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients*	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
Adult	71,838	9,866	$723,488	5,264	$73	$137	137
Aged	12,641	5,504	$455,080	1,877	$83	$242	435
Blind\Disabled	89,917	31,635	$2,647,537	11,405	$84	$232	352
Child	334,098	2,446	$90,089	1,865	$37	$48	7
CHIP 1 & 2	60,575	746	$34,846	553	$47	$63	12
Pregnant Women	25,070	282	$7,084	220	$25	$32	11
Missing Aid Category	5,729	92	$5,272	63	$57	$84	16
TOTALS	599,868	50,571	$3,963,396	21,080	$78	$188	84
4. Region of Recipient Residence	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients*	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
Central	228,070	18,289	$1,374,746	8,157	$75	$169	80
North	214,145	14,981	$1,193,605	5,918	$80	$202	70
South	157,635	17,266	$1,392,507	7,027	$81	$198	110
Missing	18	35	$2,537	16	$0	$0	0
TOTALS	599,868	50,571	$3,963,396	21,080	$78	$188	84
*The count of unique recipients is unique within each row, including the totals. A recipient may be counted in more than one row if they received prescriptions before and after a change in aid category or move across regions.							

BASELINE DATA

B. **Medical Services** Incurred Following Initial Brand Name NSAID/COX-2 Inhibitor Prescription

Calendar Year 2001 (Note: Includes First 6 Months of Calendar Year Only)

1. Office Visits Following NSAIDS/COX-2 Inhibitor Prescription in Calendar Year 2001

Days Following NSAID/COX-2 Inhibitor Prescription	Number of Office Visits	Net Payments for Office Visits	Unique Recipients*	Payment per Visit	Payment per Recipient	% of NSAID/COX-2 Inhibitor Recips with Office Visit Following Prescription
0-60	34,311	$770,730	14,217	$22	$54	67.44%
61-120	15,429	$316,185	6,875	$20	$46	32.61%
121 - 180	4,718	$98,089	2,555	$21	$38	12.12%
TOTALS	54,458	$1,185,004	15,331	$22	$77	72.73%

* Recipient may be counted in more than one row because the first prescription for each individual drug (NDC) was counted as an NSAIDS or COX-2 prescription event. The first prescription date for each individual type of drug was calculated for each recipient. Office visits were then associated with each event.

2. Inpatient Admissions Following NSAID/COX-2 Inhibitor Prescription in Calendar Year 2001

Days Following NSAID/COX-2 Inhibitor Prescription	Number of Admissions	Net Payments	Unique Recipients*	Payment per Admission	Payment per Recipient	% of NSAID/COX-2 Inhibitor Recips with Admission Visit Following Prescription
0 - 60	474	$510,504	448	$1,077	$1,140	2.13%
61 - 120	269	$247,533	259	$920	$956	1.23%
121 - 180	64	$47,000	58	$0	$0	0.28%
TOTALS	807	$805,036	728	$998	$1,106	3.45%

* Recipient may be counted in more than one row because the first prescription for each individual drug (NDC) was counted as an NSAIDS or COX-2 prescription event. The first prescription date for each individual type of drug was calculated for each recip for each recipient. Admissions were then associated with each event.

3. **Emergency Room (ER) Visits** Following NSAID/COX-2 Inhibitor Prescription in Calendar Year 2001

Days Following NSAID/COX-2 Inhibitor Prescription	Number of ER Visits	Net Payments	Unique Recipients*	Payment per ER Visit	Payment per Recipient	% of NSAID/COX-2 Inhibitor Recips with ER Visit Following Prescription
0-60	5,658	$395,574	3,917	$70	$101	18.58%
61-120	2,552	$176,432	1,778	$69	$99	8.43%
121 - 180	857	$56,025	628	$65	$89	2.98%
TOTALS	9,067	$628,031	5,230	$69	$120	24.81%

* Recipient may be counted in more than one row because the first prescription for each individual drug (NDC) was counted as an NSAIDS or COX-2 prescription event. The first prescription date for each individual type of drug was calculated for each recipient. Emergency Room Visits were then associated with each event.

Indiana Rational Drug Program (IRDP) Evaluation

Brand Name Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) and COX-2 inhibitors

Indiana Office of Medicaid Policy and Planning

POST-IMPLEMENTATION OF IRDP

A. Drug Claims Paid for Prescriptions Written January 7 to June 30, 2002

1. Age Group	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients*	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
0 - 4 years	137,453	36	$202	36	$6	$6	0
5 - 12 years	161,119	40	$810	27	$20	$30	0
13 - 17 years	73,215	35	$2,226	29	$64	$77	0
18 - 64 years	209,667	7,219	$686,858	2,958	$95	$232	34
65 to 69	13,503	1,268	$121,521	512	$96	$237	94
TOTALS	594,957	8,598	$811,616	3,562	$94	$228	14

2. Gender	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
Female	341,150	6,614	$625,087	2,738	$95	$228	19
Male	253,807	1,984	$186,529	824	$94	$226	8
TOTALS	594,957	8,598	$811,616	3,562	$94	$228	14

*The count of unique recipients is unique within each row, including the totals. A recipient may be counted in more than one row if they received prescriptions before and after a birthday.

3. Aid Category	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients*	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
Adult	74,524	789	$68,404	408	$87	$168	11
Aged	11,527	1,205	$114,252	492	$95	$232	105
Blind\Disabled	91,645	6,448	$624,487	2,558	$97	$244	70
Child	329,263	130	$3,675	104	$28	$35	0
CHIP 1 & 2	55,926	15	$601	11	$40	$55	0
Pregnant Women	23,766	8	$119	8	$15	$15	0
Missing Aid Category	8,306	3	$79	2	$26	$40	0
TOTALS	594,957	8,598	$811,616	3,562	$94	$228	14

4. Region of Recipient Residence	Eligibles (Excludes RBMC)	Number of Prescriptions	Net Payments	Unique Recipients*	Payment per Prescription	Payment per Recipient	Prescriptions per 1000 Eligible
Central	226,037	2,889	$273,643	1,189	$99	$299	13
North	204,048	2,341	$222,691	940	$94	$276	11
South	164,872	3,368	$315,282	1,438	$94	$287	20
TOTALS	594,957	8,598	$811,616	3,562	$94	$228	14

*The count of unique recipients is unique within each row, including the totals. A recipient may be counted in more than one row if they received prescriptions before and after a change in aid category or move across regions.

POST-IMPLEMENTATION OF IRDP

B. Medical Services Incurred Following Initial Brand Name NSAID/COX-2 Inhibitor Prescription

Calendar Year 2002 (Note: Includes First 6 Months of Calendar Year Only)

1. **Office Visits** Following NSAID/COX-2 Inhibitor Prescription in Calendar Year 2002

Days Following NSAID/COX-2 Inhibitor Prescription	Number of Office Visits	Net Payments for Office Visits	Unique Recipients*	Payment per Visit	Payment per Recipient	% of NSAID/COX-2 Inhibitor Recips with Office Visit Following Prescription
0-60	4,609	$108,724	2,039	$24	$53	57.24%
61-120	2,018	$45,875	990	$23	$46	27.79%
121 - 180	360	$9,432	223	$26	$42	6.26%
TOTALS	6,987	$164,032	2,524	$23	$65	70.86%

* Recipient may be counted in more than one row because the first prescription for each individual drug (NDC) was counted as an NSAIDS or COX-2 prescription event. The first prescription date for each individual type of drug was calculated for each recipient.
Office visits were then associated with each event.

2. **Inpatient Admissions** Following NSAID/COX-2 Inhibitor Prescription in Calendar Year 2002

Days Following NSAID/COX-2 Inhibitor Prescription	Number of Admissions	Net Payments	Unique Recipients*	Payment per Admission	Payment per Recipient	% of NSAID/COX-2 Inhibitor Recips with Office Visit Following Prescription
0 - 60	66	$52,688	66	$798	$798	1.85%
61 - 120	27	$21,721	27	$804	$804	0.76%
121 - 180	0	$0	0	$0	$0	0.00%
TOTALS	93	$74,409	93	$800	$800	2.61%

* Recipient may be counted in more than one row because the first prescription for each individual drug (NDC) was counted as an NSAIDS or COX-2 prescription event. The first prescription date for each individual type of drug was calculated for each recipient.
Admissions were then associated with each event.

3. **Emergency Room (ER) Visits** Following NSAID/COX-2 Inhibitor Prescription in Calendar Year 2002

Days Following NSAID/COX-2 Inhibitor Prescription	Number of ER Visits	Net Payments	Unique Recipients*	Payment per ER Visit	Payment per Recipient	% of NSAID/COX-2 Inhibitor Recips with Office Visit Following Prescription
0-60	804	$34,498	530	$43	$65	14.88%
61-120	295	$13,117	222	$44	$59	6.23%
121 - 180	47	$2,117	37	$45	$57	1.04%
TOTALS	1,146	$49,731	651	$43	$76	18.28%

Recipient may be counted in more than one row because the first prescription for each individual drug (NDC) was counted as an NSAIDS or COX-2 prescription event. The first prescription date for each individual type of drug was calculated for each recipient. Emergency Room Visits were then associated with each event.

Memo

From Kate Whitaker, RN, MBA To Indiana Medicaid DUR Board

Date December 20, 2002

Subject Follow-up to NSAID/COX-2 Inhibitor Study

At the November 15, 2002 meeting, Medstat presented a preliminary study evaluating the effects of the Indiana Rational Drug Program on the prescription patterns, outcomes and costs associated with Nonsteroidal Anti-inflammatory Drugs (NSAIDs) and COX-2 Inhibitors. Upon review of the reports, the DUR board requested follow-up on three particular areas. The Board is interested in the diagnoses associated with the emergency room visits reported, whether opioids are being prescribed at a higher rate following IRDP implementation and additional information regarding the increase in cost per prescription.

1. What were the diagnoses associated with emergency room visits for individuals who received a prescription for an NSAID or COX-2 that required prior authorization (PA) under the IRDP?
The Board is interested in further evaluation to determine the reason recipients were admitted to an emergency room. Three types of recipients were studied in the preliminary reports. Cohort 1 included individuals who were denied prior authorization for an NSAID or COX-2 inhibitor and prescribed a substitute medication. Cohort 2 included those who were also denied prior authorization, but received no substitute medication. Cohort 3 included those who received a prior authorization approval and were dispensed an NSAID or COX-2 inhibitor. The Board was interested in evaluating if there was a difference in the reasons for emergency room visits across the three groups.

In order to respond to this question, Medstat queried the DataProbe decision support system and evaluated the incurred database for each of the three cohorts identified in the original study. There was not a significant difference in the primary diagnoses for emergency room visits across the three groups. Individuals with PA denials and with PA approvals were most likely to visit the ER complaining of chest pain. Other common diagnoses were abdominal pain and headache/migraine.

a. Top 10 Diagnoses for Emergency Room Visits by Individuals Denied Prior Authorization for NSAID or COX-2 Inhibitor

Cohort 1: PA Denied and Substitute Medication Prescribed			Cohort 2: PA Denied and No Substitute Medication Prescribed		
Primary Diagnosis	ER Visits	Recipients	Primary Diagnosis	ER Visits	Recipients
Chest Pain	27	23	Chest Pain NOS	26	18
Lumbago	21	12	Vomiting Alone	8	4
Headache	18	15	Migraine	7	5
Pain in Limb	15	15	Abdominal Pain	7	5
Abdominal Pain	14	10	Abdominal Pain, other site	7	6
Backache	13	10	Pain in Limb	6	6
Shortness of Breath	11	11	Headache	6	5
Joint Pain – L/limb	9	4	Abdominal Pain, Unspec	6	6
Migraine	8	5	Noninf Gastroenteritis	5	4
Joint Pain - Ankle	7	5	Urin Tract Infection	5	4

Top 10 Diagnoses for Emergency Room Visits by Individuals Approved Prior Authorization for NSAID or COX-2 Inhibitor

Cohort 3: PA for NSAID or COX-2 Inhibitor Approved		
Primary Diagnosis	ER Visits	Recipients
Chest Pain	133	107
Headache	102	76
Lumbago	95	64
Pain in Limb	95	73
Backache NOS	82	62
Abdominal Pain, Unspecified Site	77	60
Cough	73	64
Migraine	60	31
Fever	54	48
Joint Pain -L/Leg	51	31

2. Additional Evaluation of Impact on Expenditures

Hospitalizations, emergency room visits and office visits are not homogenous despite an identical or similar diagnosis. Severity of illness and utilization of services result in variance in costs. Therefore, it is of value to attempt to determine whether the IRDP had any effect on total health care expenditures. Higher costs per recipient may indicate that patients receiving NSAIDs or COX-2 inhibitors following implementation of the IRDP are sicker than those who received the drugs prior to the IRDP. Before any dollar comparisons are made, the CY01 figures must be adjusted for inflation and put in CY02 dollar terms. This is done by using a simple multiplier (i.e., multiply all dollars in CY01 by an inflation factor of 1.02, since inflation over the last year has been running at 2%, according to the Bureau of Labor Statistics). If this is not done, we cannot distinguish between the impact of normal inflation in the US economy versus the impact of the IRDP program on expenditures of interest.

Additionally, in order to get the most accurate picture of expenditures in SFY 2002, the hospitalization, emergency room, and office visit data was reproduced using the database updated through September 30, 2002. There are claims that were incurred during the first six months of 2002 that were not paid prior to June 30, 2002. These data were not available at the time the initial study was produced. Figure 1 displays the results.

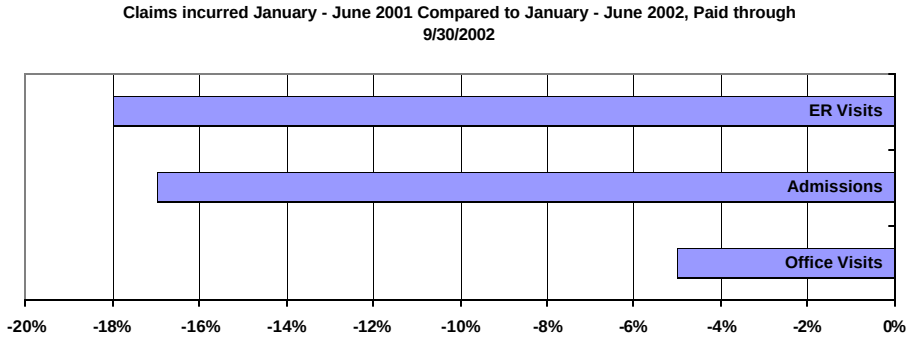


Figure 1. Change in Expenditures per 1000 Recipients for Medical Services Following NSAID or COX-2 Inhibitor Prescription, Source: DataProbe ® Paid Claims Database

Are opioids being prescribed at a higher rate following implementation of the IRDP for NSAIDS and COX-2 Inhibitors?

The data do indicate an increase in opioid prescriptions when drugs prescribed during the first six months of Calendar Year 2001 are compared to drugs prescribed during the same time period in Calendar Year 2002. In order to evaluate the issue further, a pilot study was created as follows:

Individuals who were denied prior authorization for an NSAID or COX-2 Inhibitor and not prescribed a substitute medication (Cohort 2) during the period of January 1, 2002 to June 30, 2002 were selected as the study group.
A subset of opioid prescriptions between January 1, 2001 and June 30, 2001 was created using the state fiscal year 2001 drug table from the DataProbe ® Incurred Database. (2001 Opioid Claims)
The Cohort 2 individuals were linked to the 2001 Opioid Claims to determine how many prescriptions for opioids they received prior to implementation of the IRDP for NSAIDS and COX-2 Inhibitors
A subset of opioid prescriptions between January 1, 2002 and June 30, 2002 was created using the state fiscal year 2001 drug table from the DataProbe ® Incurred Database. (2002 Opioid Claims).
The Cohort 2 individuals were linked to the 2002 Opioid Claims to determine how many prescriptions for opioids they received following implementation of the IRDP for NSAIDS and COX-2 Inhibitors.

The table below displays the results:

Date Prescribed	Cohort 2 Persons Eligible	Number of Opioid Prescriptions	Number of Recipients of Opioid Prescriptions	Prescriptions Per Cohort 2 Eligible
January to June 2001	512	1,634	282	3.19
January to June 2002	625	4,846	437	7.75

There were 625 individuals between January and June 2002 who were denied prior authorization for a brand name NSAID or COX-2 Inhibitor and did not receive a substitute generic medication. Of the 625 individuals, 437 (70%) received at least one prescription for an opioid. Of the 625 individuals, 512 were also enrolled in Medicaid during the period between January and June of 2001. Of the 512 individuals, 282 (55%) received at least one prescription for an opioid. Therefore, it does appear that prescriptions for opioids have increased since implementation of the IRDP for brand name NSAIDS and COX-2 Inhibitors. Additional study would be necessary to confirm that the opioid medications are being prescribed for conditions for which brand name NSAIDS or COX-2 Inhibitors were previously prescribed.

Is there an explanation, beyond inflation for the increase in price per prescription for brand name NSAIDS and COX-2 Inhibitors between Calendar Years 2001 and 2002?

The primary driver of the increase in cost per prescription is that a higher percentage of the prescriptions were for COX-2 Inhibitors, specifically Celecoxib (Celebrex). The following table illustrates the findings related to Celecoxib.

The increased cost and increased percentage of total prescriptions for COX-2 Inhibitors resulted in a higher Medicaid expenditure per prescription for the Brand Name NSAIDs and COX-2 Inhibitors as a group. At the same time, due to the significant decrease in prescriptions for these drugs and the shift to generic NSAIDS, the overall net payments decreased.

Date Celecoxib Prescribed	Number of Scripts	Percent of Total NSAIDS/ COX-2 Scripts	Expenditure per Script	Percent of Total NSAIDS/COX-2 Expenditures
January to June 2001	21,338	42	$90	48
January to June 2002	4,554	53	$106	60

Source: DataProbe Incurred Claims Database, State Fiscal Year 2001 and 2002 Drug Tables

Indiana Rational Drug Program (IRDP) Evaluation
Peptic Acid Disease Therapy

Executive Summary

The Indiana Medicaid Drug Utilization Review Board requested that the Office of Medicaid Policy and Planning (OMPP) develop and produce reports to evaluate the impact of the Indiana Rational Drug Program (IRDP) on the prescribing patterns of Proton Pump Inhibitors for peptic acid disease. The evaluation has two primary objectives. One objective is to use retrospective, paid claims data to analyze the impact of the IRDP on prescribing patterns, Medicaid drug expenditures, and drug utilization. The other objective is to use retrospective, paid claims data, to the extent possible, to evaluate recipient outcomes that may be related to implementation of the IRDP.

The principal finding of the study was that the total number of prescriptions, the total expenditures for PPIs and the number of prescriptions per recipient decreased following implementation of the IRDP. Overall, there was a decrease of $4.4 million in expenditures following implementation of the IRDP.

The most significant decrease in the number of prescriptions per enrollee occurred for individuals 65 years of age and older. These individuals also had the highest rate of PPI prescriptions per 1000 enrollees prior to implementation of the IRDP. Therefore, the data indicate that the IRDP had the most significant impact on utilization for the heaviest users of Proton Pump Inhibitors.

Within the parameters of this study, including the limitations of administrative data, it was not possible to definitively correlate the prior authorization determination with the rate of subsequent health care encounters. When health care encounter rates for those who received PPIs were compared to those for whom prior authorization was denied, those with denials had lower utilization rates. Many other variables must be considered and external data sources are necessary to establish correlation.

The Proton Pump Inhibitors were placed on the Preferred Drug List effective September 25, 2002 and are no longer under the IRDP.

Indiana Rational Drug Program (IRDP) Evaluation
Peptic Acid Disease Therapy

Introduction

A. Objectives

The Indiana Medicaid Drug Utilization Review Board requested that the Office of Medicaid Policy and Planning (OMPP) develop and produce reports to evaluate the impact of the Indiana Rational Drug Program (IRDP). The program, requiring prior authorization for specific classes of drugs, was implemented on January 7, 2002.

The evaluation has two primary objectives. One objective is to use retrospective, paid claims data to analyze the impact of the IRDP on prescribing patterns, Medicaid drug expenditures, and drug utilization. The other objective is to use retrospective, paid claims data, to the extent possible, to evaluate recipient outcomes that may be related to implementation of the IRDP.

B. Methodology

The data source is the Medstat DataProbe® Decision Support System, Indiana Medicaid paid claims database.

A study design was prepared by OMPP and presented to the DUR Board for review and approval. A preliminary report on the findings related to Proton Pump Inhibitors (PPIs) used for peptic acid disease therapy was presented at the November 15, 2002 Board meeting.

The preliminary study included data related to prescriptions incurred between April and June 2001 and April and June 2002. The April start date was chosen as this is the first date that requests for prior authorization began to occur due to the provision of a 90 day period for initial therapy outlined in the IRDP guidelines. Since the preliminary study, the database has been updated to include drug claims paid through March 31, 2003.

For the purposes of this study, the time frame was expanded to encompass PPI prescriptions beginning in January 2002 and ending September 24, 2002. Because PPIs were prescribed within the first 90 days of implementation of the IRDP, it was determined that all claims beginning January 7, 2002 would be included in this study. The end date for the range is September 24 because effective September 25, 2002, PPI drugs were placed on the Preferred Drug List.

The time periods under study are:

Pre IRDP	1/7/01 to 9/24/01
Post IRDP	1/7/02 to 9/24/02

Besides the timeframes, another important difference from the preliminary study is that the identification of health care encounters is not limited to claims where there was a diagnosis of peptic acid disease. In the preliminary study, it was found that very few medical claims actually included a diagnosis of peptic acid disease. Limiting the medical encounter claims to only those including these diagnoses resulted in a very limited number of encounters. Additionally, in studying outcomes, we are interested in evaluating the impact of the IRDP on general health and not only the treatment of peptic acid disease.

1. Utilization and Expenditure Measures

In order to evaluate changes in prescribing patterns and expenditures, the preliminary analysis includes a comparison of data regarding drugs prescribed from January to September 2001 (prior to implementation of the IRDP) to drugs prescribed from January to September, 2002 (following implementation of the IRDP).

The following measures are included:

- Number of Medicaid Eligible Persons
- Number of Prescriptions
- Expenditures for Prescriptions
- Unique Number of Recipients
- Payments per Prescription
- Payments per Recipient
- Prescriptions per 1000 Eligible Persons

The above measures are categorized by Age Group, Aid Category, Region of Residence and Totals.

2. Outcomes

The DUR Board is interested in the impact that the IRDP may have on quality of care. In order to get a general idea of the utilization trends for people prescribed IRDP drugs, paid claims data for medical claims were also analyzed. While the health care encounters may not be attributable to conditions involving the drugs, the data provide a general picture of the utilization patterns. Variations in the patterns may raise questions for further investigation.

The health care encounters included in the study are physician office visits (excluding preventive services), inpatient hospital admissions, and emergency room visits. Having identified recipients of Proton Pump Inhibitors, outcomes reports were produced by linking these recipients to

medical claims incurred following the prescription.

Another component of the study is the evaluation of patient outcomes for those with a denial for PPI drug therapy through the IRDP prior authorization (PA) program. Health care encounters incurred following a denial for PPI were identified for individuals with a denied request for one of the drugs.

C. Organization of Report

The first section of the report provides an overview of the baseline information regarding peptic acid disease drug utilization, including year-to-year comparisons. The second section provides an overview of the health care experience of recipients following a peptic acid disease drug prescription. Attachment A includes the detailed data from which the summaries were drawn.

II. Overview of Peptic Acid Disease Prescription Data

A. Summary Prescription Rates and Expenditures

1. Prescriptions per 1000 Eligible Persons

Time Period	PPI Prescriptions	Eligible Persons*	Prescriptions per 1000 Eligible Persons	Net Payments	Payments per Prescription
Jan to Sept 2001	146,413	676,571	216	$18,809,656	$128
Jan to Sept 2002	111,740	690,577	162	$14,438,164	$129
Change	(34,673)	14,006	(54)	($4,371,492)	$1
Percent Change	(24%)	2%	(25%)	(23%)	1%

* Eligible persons were calculated using monthly eligibility tables for State Fiscal Years 2001 and 2002. The number reflects the unique Medicaid enrollees, excluding RBMC members, for the time period.

2. Expenditures for PPI prescriptions per Recipient

Time Period	PPI Prescriptions	Unique Recipients	Prescriptions per Recipient	Net Payments	Payments per Recipient
Jan to Sept 2001	146,413	31,369	4.7	$18,809,656	$600
Jan to Sept 2002	111,740	34,077	3.3	$14,438,164	$424
Change	(34,673)	2,708	(1.4)	($4,371,492)	($176)
Percent Change	(24%)	9%	(30%)	(23%)	(29%)

Discussion

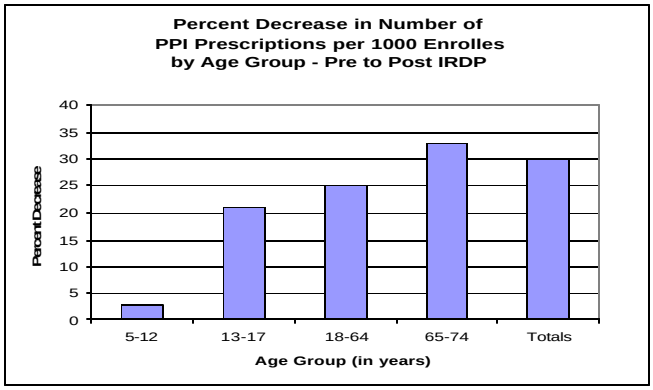
There was a 24% decrease in PPI prescriptions when comparing the period January to September, 2001 with the same dates in 2002. The Net Payments for all PPI prescriptions decreased by 23%. Because payments per prescription increased by only 1%, the decrease in total payments appears to be driven by the overall decrease in total prescriptions filled.

There was a 29% decrease in payments per recipient. This finding coincides with the decrease in prescriptions per recipient from 4.7 to 3.3 across the two time periods, which is a 30% change. The overall decrease in the number of prescriptions resulted in a net savings of $4.4 million.

These data include all original prescriptions and refills and do not take dosage into account. While information regarding package size, route and strength is available in the administrative data, frequency (e.g., twice daily) is not present.

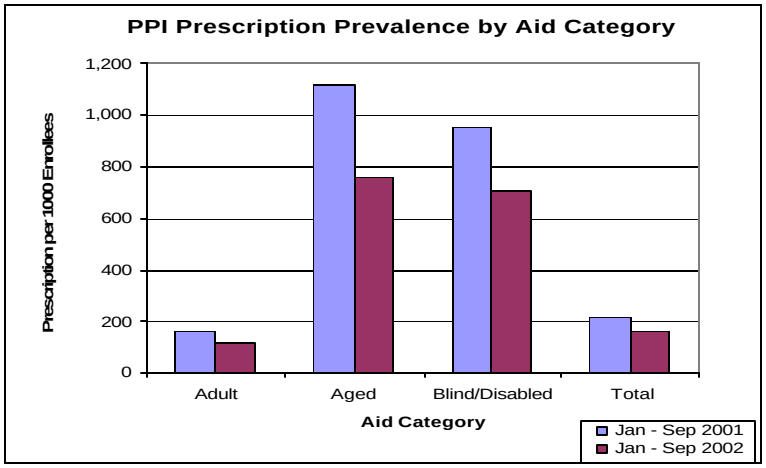
Age Group Information

The graph below illustrates the percent decrease in PPI prescriptions per 1000 Medicaid Enrollees from the pre-IRDP period of January to September 2001 to the post-IRDP period of January to September 2002. The 65 to 74 year old age group experienced the largest decrease in PPI prescriptions per enrollee at 33%. The data appears to support the finding that the heaviest utilizers of PPI drugs experienced the most significant decrease in number of prescriptions. Additionally, the number of prescriptions per recipient of PPI therapy in this age group decreased from 5.2 per recipient to 3.5 per recipient, which is also a 33% change.



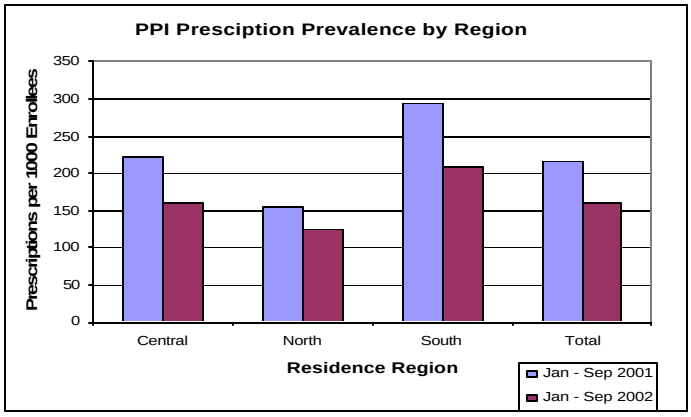
C. Aid Category Information

The most significant number of prescriptions was written for those in the Adult, Aged and Blind/Disabled Aid Categories. Therefore, only the results for these groups are displayed below. The totals column reflects the findings for all aid categories.



Region of Residence Information

The highest rate of PPI prescriptions per enrollee was in the Southern Region and the lowest rate was in the Northern Region. The rate of PPI prescriptions per thousand enrollees decreased by 29% in the Southern Region as compared with the Northern Region where the rate decreased by 19% across the two time periods.



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III. Outcomes Studies

A. Introduction

Reports were produced to identify the number of inpatient admissions, physician office visits and emergency room visits experienced by recipients following a prescription for a Proton Pump Inhibitor (PPI). There is no established direct correlation between the PPI prescription and the health care encounter.

Heath Care Encounter Experience for Recipients of Peptic Acid Disease Drugs

The following table illustrates the findings for recipients of PPI drugs, comparing pre-IRDP experience with post-IRDP experience.

Date PPI Dispensed	Unique Recipients of PPI drugs	% of PPI Recipients with Office Visit Following Prescription	% of PPI Recipients with Admission Following Prescription	% of PPI Recipients with ER Visit Following Prescription
Jan to Sept 2001 (pre-IRDP)	31,369	79.8%	20.6%	43.1%
Jan to Sept 2002 (post-IRDP)	34,077	80.5%	20.8%	44.1%
Change	2,708	1.0%	0.3%	1.0%

These rates were calculated based on all health care encounters, regardless of the principal diagnosis. The primary or secondary reason for the health care encounter may have been unrelated to the prescription or to the condition for which the drug was prescribed. The report provides a high level picture of the utilization of these services for patients who had prescriptions for PPIs.

Using this method of analysis, there was no difference in the outcomes for recipients of PPI therapy pre and post-implementation of the IRDP for PPI drugs.

Heath Care Encounter Experience for Enrollees with Denied Prior Authorization Requests for Peptic Acid Disease Drugs

In order to evaluate the potential impact of denials for prior authorization for PPI drugs, an analysis of the experience of enrollees who received denials was conducted. The analysis includes data on the experience of the individuals following denial as compared to their experience in the year prior to the IRDP. In addition to the general experience, the data were evaluated to determine if the individuals received PPI therapy in the year prior to implementation of the IRDP.

There were 2,830 unique individuals for whom a prior authorization request for PPI therapy was made and denied through the IRDP. Of these individuals, 63% were aged 18-64 years and 15% were aged 65 years and older.

Comparison of Heath Care Encounter Experience for Enrollees with Approved and Denied Prior Authorization Requests for Peptic Acid Disease Drugs

The following table compares the health care encounter experience of individuals to whom at least one PPI was dispensed following implementation of the IRDP to those who were denied prior authorization for a PPI.

PPI Status	Unique Enrollees	% Enrollees with Office Visit	% Enrollees with Admission	% Enrollees with ER Visit
PPI Dispensed Jan-Sept 2002	34,077	81%	21%	44%
Prior Authorization Denied	2,830	63%	11%	26%

The data would appear to show a lower rate of encounters for individuals who had a request for prior authorization denied. In order to attribute outcomes to a particular prior authorization decision, a correlation between the decision and the reason for the health care encounter must be established. There are many variables that must be considered in establishing this correlation including patient age, health status, co morbidities and the condition or disease that required intervention or management. Additional study involving medical record or detailed prior authorization data review is required to establish this relationship.

IV. Summary

The IRDP impact analysis for PPIs found that there was a decrease in the total number of PPI prescriptions, a decrease in the number of prescriptions per recipient, and a savings of $4.4 million. While there was a decrease in the number of PPI prescriptions, the impact on recipients in terms of outcomes was not clearly defined.

Following are the key findings of the study:

There was a 24% decrease in prescriptions for Proton Pump Inhibitors following implementation of the Indiana Rational Drug Program (IRDP) on January 7, 2002.

There was a 23% decrease in total Medicaid expenditures for Proton Pump Inhibitors following IRDP implementation which appears to be driven by the decrease in the number of prescriptions. The program savings were $4.4 million. The cost per prescription rose by $1 which is an expected finding due to inflation.

The number of Proton Pump Inhibitor prescriptions per recipient decreased from 4.7 per recipient during the initial time period to 3.3 per recipient during the post IRDP time frame.

Recipients of PPI prescriptions had a similarrate of office visits, emergency room visits and inpatient admissions across the two time periods under study.

When health care encounter rates for individuals with a prior authorization denial were compared with rates for individuals who received the drugs, it appeared that those with denials had a lower rate of office visits, emergency room visits and inpatient admissions. However, a correlation was not established based on a simple statistical analysis and further study would be necessary to establish a correlation between the prior authorization determination and the number and rate of encounters.

Proton Pump Inhibitors have been removed from the list of drugs under the Indiana Rational Drug Program and are now on the Preferred Drug List.

Summary Statistics for Proton Pump Inhibitor Prescriptions

RBMC Members are excluded.

Date Dispensed	Unique Enrollees	PPI Prescriptions	Unique Recipients	Prescriptions per 1000 Enrollees	Net Payments	Average Pmt per Prescription	Pmt per Recipient
January to September 2001	676,571	146,413	31,369	216	$18,809,656	$128	$600
January to September 2002	690,577	111,740	34,077	162	$14,438,164	$129	$424
Change	14,006	(34,673)	2,708	(55)	($4,371,492)	$1	($176)
Percent Change	2.1%	-23.7%	8.6%	-25.2%	-23.2%	0.6%	-29.3%

Statistics for Proton Pump Inhibitor Prescriptions by Age Group

1. Prescriptions (Scripts) per 1000 Enrollees

	January - September 2001			January - September 2002				
Age In Years	Total Scripts	Enrollment	Scripts per 1000 Enrollees	Total Scripts	Enrollment	Scripts per 1000 Enrollees	Change	Percent Change
0-4	544	157,545	3.5	770	154,771	5.0	1.5	44.1%
5-12	1,180	177,356	6.7	1,157	179,277	6.5	-0.2	-3.0%
13-17	2,728	77,873	35.0	2,292	82,439	27.8	-7.2	-20.6%
18-64	110, 718	233,759	473.6	85,841	243,031	353.2	-120.4	-25.4%
65-74	31,243	30,038	1040.1	21,680	31,059	698.0	-342.1	-32.9%
Totals	146,413	676,571	216.4	111,740	690,577	161.8	-54.6	-25.2%

2. Prescriptions per Recipient

	January to September 2001			January to September 2002				
Age In Years	Prescriptions	Unique Recipients	Prescriptions per Recipient	Prescriptions	Unique Recipients	Prescriptions per Recipient	Change	Percent Change
0-4	544	217	2.5	770	307	2.5	0.0	0.0%
5-12	1,180	422	2.8	1,157	494	2.3	-0.5	-16.2%
13-17	2,728	1,041	2.6	2,292	1,046	2.2	-0.4	-16.4%
18-64	110,718	23,980	4.6	85,841	26,181	3.3	-1.3	-29.0%
65-74	31,243	6,034	5.2	21,680	6,270	3.5	-1.7	-33.2%
Totals	146,413	31,369	4.7	111,740	34,077	3.3	-1.4	-29.7%

3. Expenditures per Recipient

	January to September 2001			January to September 2002			Expenditures per Recipient	
Age In Years	Expenditures	Unique Recipients	Expenditures per Recipient	Expenditures	Unique Recipients	Expenditures per Recipient	Change	Percent Change
0-4	$55,214	217	$254	$75,312	307	$245	-9.1	-3.6%
5-12	$150,286	422	$356	$156,531	494	$317	-39.3	-11.0%
13-17	$316,975	1,041	$304	$274,226	1,046	$262	-42.3	-13.9%
18-64	$14,385,264	23,980	$600	$11,191,499	26,181	$427	-172.4	-28.7%
65-74	$3,901,917	6,034	$647	$2,740,596	6,270	$437	-209.6	-32.4%
Totals	$18,809,656	31,369	$600	$14,438,164	34,077	$424	-175.9	-29.3%

Statistics for Proton Pump Inhibitor Prescriptions by Aid Category

1. Prescriptions (Scripts) per 1000 Enrollees

	January to September 2001			January to September 2002			Expenditures per Recipient	
Aid Category	Total Scripts	Enrollment	Scripts per 1000 Enrollees	Total Scripts	Enrollment	Scripts per 1000 Enrollees	Change in scripts/ 1000	Percent Change
Adult	16,896	104,992	160.9	13,410	110,593	121.3	-39.7	-24.7%
Aged	30,924	27,585	1,121.0	21,396	28,085	761.8	-359.2	-32.0%
Blind/Disabled	93,235	97,877	952.6	72,208	101,767	709.5	-243.0	-25.5%
Child	3,823	378,038	10.1	3,824	385,051	9.9	-0.2	-1.8%
Pregnant Women	1,325	56,246	23.6	855	52,924	16.2	-7.4	-31.4%
Missing	210	11,833	17.7	47	12,157	3.9	-13.9	-78.2%
Total	146,413	676,571	216.4	111,740	690,577	161.8	-54.6	-25.2%

2. Prescriptions per Recipient

	January to September 2001			January to September 2002			Expenditures per Recipient	
Aid Category	Prescriptions	Unique Recipients	Prescriptions per Recipient	Prescriptions	Unique Recipients	Prescriptions per Recipient	Change	Percent Change
Adult	16,896	5,564	3.0	13,410	5,718	2.3	-0.7	-22.8%
Aged	30,924	5,961	5.2	21,396	6,194	3.5	-1.7	-33.4%
Blind/Disabled	93,235	18,163	5.1	72,208	20,267	3.6	-1.6	-30.6%
Child	3,823	1,625	2.4	3,824	1,870	2.0	-0.3	-13.1%
Pregnant Women	1,325	536	2.5	855	450	1.9	-0.6	-23.1%
Missing	210	173	1.2	47	45	1.0	-0.2	-14.0%
Total	146,413	31,369	4.7	111,740	34,077	3.3	-1.4	-29.7%

3. Expenditures per Recipient

	January to September 2001			January to September 2002			Expenditures per Recipient	
Aid Category	Expenditures	Unique Recipients	Expenditures per Recipient	Expenditures	Unique Recipients	Expenditures per Recipient	Change	Percent Change
Adult	$2,071,080	5,564	$372.2	$1,645,162	5,718	$287.7	-$84.5	-22.7%
Aged	$3,862,190	5,961	$647.9	$2,701,300	6,194	$436.1	-$211.8	-32.7%
Blind/Disabled	$12,264,950	18,163	$675.3	$9,545,206	20,267	$471.0	-$204.3	-30.3%
Child	$436,216	1,625	$268.4	$438,246	1,870	$234.4	-$34.1	-12.7%
Pregnant Women	$155,622	536	$290.3	$102,315	450	$227.4	-$63.0	-21.7%
Missing	$19,598	173	$113.3	$5,934	45	$131.9	$18.6	16.4%
Total	$18,809,656	31,369	$599.6	$14,438,164	34,077	$423.7	-$175.9	-29.3%

Statistics for Proton Pump Inhibitor Prescriptions by Region of Residence

1. Prescriptions (Scripts) per 1000 Enrollees

	January to September 2001			January to September 2002				
Region	Prescriptions	Enrollment	Scripts per 1000 Enrollees	Prescriptions	Enrollment	Scripts per 1000 Enrollees	Change in scripts/ 1000	Percent Change
Central	57,590	259,504	221.9	42,938	266,603	161.1	-60.9	-27.4%
North	37,426	242,153	154.6	29,399	236,248	124.4	-30.1	-19.5%
South	51397	174,914	293.8	39,403	187,726	209.9	-83.9	-28.6%
Total	146,413	676,571	216.4	111,740	690,577	161.8	-54.6	-25.2%

2. Prescriptions per Recipient

	January to September 2001			January to September 2002				
Region	Prescriptions	Unique Recipients	Prescriptions per Recipient	Prescriptions	Unique Recipients	Prescriptions per Recipient	Change	Percent Change
Central	57,590	12,483	4.6	42,938	13,331	3.2	-1.4	-30.2%
North	37,426	8,397	4.5	29,399	9,215	3.2	-1.3	-28.4%
South	51,397	10,653	4.8	39,403	11,617	3.4	-1.4	-29.7%
Total	146,413	31,369	4.7	111,740	34,077	3.3	-1.4	-29.7%

3. Expenditures per Recipient

	January to September 2001			January to September 2002				
Region	Expenditures	Unique Recipients	Expenditures per Recipient	Expenditures	Unique Recipients	Expenditures per Recipient	Change	Percent Change
Central	$7,514,523	12,483	$602.0	$5,632,295	13,331	$422.5	-$179.5	-29.8%
North	$4,755,794	8,397	$566.4	$3,737,168	9,215	$405.6	-$160.8	-28.4%
South	$6,539,339	10,653	$613.8	$5,068,701	11,617	$436.3	-$177.5	-28.9%
Total	$18,809,656	31,369	$599.6	$14,438,164	34,077	$423.7	-$175.9	-29.3%

Outcome Statistics for Proton Pump Inhibitor Prescriptions

1. Recipients with PPI Prescriptions Before and After IRDP implemented

Date of Service	PPI Recips	No of Office Visits	Recips with Office Visits	% Recips with Office Visits	No of Inpatient Admissions	Recips with Inpatient Admissions	% Recips with Inpatient Admissions	No of ER Visits
Jan to Sept 2001 Pre IRDP	31,369	139,645	25,018	79.8%	9,408	6,447	20.6%	33,941
Jan to Sept 2002 Post IRDP	34,077	156,562	27,426	80.5%	10,171	7,099	20.8%	38,259
Change	2,708	16,917	2,408	0.7%	763	652	0.3%	4,318

2. Recipients with Prior Authorization Denial for PPI Prescriptions

Date of Prior Authorization Request	Recips	No of Office Visits	Recips with Office Visits	% Recips with Office Visits	No of Inpatient Admissions	Recips with Inpatient Admissions	% Recips with Inpatient Admissions	No of ER Visits
Jan to Sept 2002	2,830	6,389	1,776	62.8%	356	302	10.7%	1,340

Statistics for Proton Pump Inhibitor Prescriptions by Age Group

1. Prescriptions (Scripts) per 1000 Enrollees

	January - September 2001			January - September 2002		
Age In Years	Total Scripts	Enrollment	Scripts per 1000 Enrollees	Total Scripts	Enrollment	Scripts per 1000 Enrollees
0-4	544	157,545	3.5	770	154,771	5.0
5-12	1,180	177,356	6.7	1,157	179,277	6.5
13-17	2,728	77,873	35.0	2,292	82,439	27.8
18-64	110,718	233,759	473.6	85,841	243,031	353.2
65-74	31,243	30,038	1040.1	21,680	31,059	698.0
Totals	146,413	676,571	216.4	111,740	690,577	161.8

2. Prescriptions per Recipient

	January to September 2001			January to September 2002		
Age In Years	Prescriptions	Unique Recipients	Prescriptions per Recipient	Prescriptions	Unique Recipients	Prescriptions per Recipient
0-4	544	217	2.5	770	307	2.5
5-12	1,180	422	2.8	1,157	494	2.3
13-17	2,728	1,041	2.6	2,292	1,046	2.2
18-64	110,718	23,980	4.6	85,841	26,181	3.3
65-74	31,243	6,034	5.2	21,680	6,270	3.5
Totals	146,413	31,369	4.7	111,740	34,077	3.3

3. Expenditures per Recipient

	January to September 2001			January to September 2002		
Age In Years	Expenditures	Unique Recipients	Expenditures per Recipient	Expenditures	Unique Recipients	Expenditures per Recipient
0-4	$55,214	217	$254	$75,312	307	$245
5-12	$150,286	422	$356	$156,531	494	$317
13-17	$316,975	1,041	$304	$274,226	1,046	$262
18-64	$14,385,264	23,980	$600	$11,191,499	26,181	$427
65-74	$3,901,917	6,034	$647	$2,740,596	6,270	$437
Totals	$18,809,656	31,369	$600	$14,438,164	34,077	$424

Statistics for Proton Pump Inhibitor Prescriptions by Aid Category

1. Prescriptions (Scripts) per 1000 Enrollees

	January to September 2001			January to September 2002		
Aid Category	Total Scripts	Enrollment	Scripts per 1000 Enrollees	Total Scripts	Enrollment	Scripts per 1000 Enrollees
Adult	16,896	104,992	160.9	13,410	110,593	121.3
Aged	30,924	27,585	1,121.0	21,396	28,085	761.8
Blind/Disabled	93,235	97,877	952.6	72,208	101,767	709.5
Child	3,823	378,038	10.1	3,824	385,051	9.9
Pregnant Women	1,325	56,246	23.6	855	52,924	16.2
Missing	210	11,833	17.7	47	12,157	3.9
Total	146,413	676,571	216.4	111,740	690,577	161.8

2. Prescriptions per Recipient

	January to September 2001			January to September 2002		
Aid Category	Prescriptions	Unique Recipients	Prescriptions per Recipient	Prescriptions	Unique Recipients	Prescriptions per Recipient
Adult	16,896	5,564	3.0	13,410	5,718	2.3
Aged	30,924	5,961	5.2	21,396	6,194	3.5
Blind/Disabled	93,235	18,163	5.1	72,208	20,267	3.6
Child	3,823	1,625	2.4	3,824	1,870	2.0
Pregnant Women	1,325	536	2.5	855	450	1.9
Missing	210	173	1.2	47	45	1.0
Total	146,413	31,369	4.7	111,740	34,077	3.3

Prepared by The Medstat Group

3. Expenditures per Recipient

	January to September 2001			January to September 2002		
Aid Category	Expenditures	Unique Recipients	Expenditures per Recipient	Expenditures	Unique Recipients	Expenditures per Recipient
Adult	$2,071,080	5,564	$372.2	$1,645,162	5,718	$287.7
Aged	$3,862,190	5,961	$647.9	$2,701,300	6,194	$436.1
Blind/Disabled	$12,264,950	18,163	$675.3	$9,545,206	20,267	$471.0
Child	$436,216	1,625	$268.4	$438,246	1,870	$234.4
Pregnant Women	$155,622	536	$290.3	$102,315	450	$227.4
Missing	$19,598	173	$113.3	$5,934	45	$131.9
Total	$18,809,656	31,369	$599.6	$14,438,164	34,077	$423.7

Statistics for Proton Pump Inhibitor Prescriptions by Region of Residence

1. Prescriptions (Scripts) per 1000 Enrollees

	January to September 2001			January to September 2002		
Region	Prescriptions	Enrollment	Scripts per 1000 Enrollees	Prescriptions	Enrollment	Scripts per 1000 Enrollees
Central	57,590	259,504	221.9	42,938	266,603	161.1
North	37,426	242,153	154.6	29,399	236,248	124.4
South	51397	174,914	293.8	39,403	187,726	209.9
Total	146,413	676,571	216.4	111,740	690,577	161.8

2. Prescriptions per Recipient

	January to September 2001			January to September 2002		
Region	Prescriptions	Unique Recipients	Prescriptions per Recipient	Prescriptions	Unique Recipients	Prescriptions per Recipient
Central	57,590	12,483	4.6	42,938	13,331	3.2
North	37,426	8,397	4.5	29,399	9,215	3.2
South	51,397	10,653	4.8	39,403	11,617	3.4
Total	146,413	31,369	4.7	111,740	34,077	3.3

3. Expenditures per Recipient

	January to September 2001			January to September 2002		
Region	Expenditures	Unique Recipients	Expenditures per Recipient	Expenditures	Unique Recipients	Expenditures per Recipient
Central	$7,514,523	12,483	$602.0	$5,632,295	13,331	$422.5
North	$4,755,794	8,397	$566.4	$3,737,168	9,215	$405.6
South	$6,539,339	10,653	$613.8	$5,068,701	11,617	$436.3
Total	$18,809,656	31,369	$599.6	$14,438,164	34,077	$423.7

The preparation of this document was financed under an agreement with Indiana OMPP.

Outcome Statistics for Proton Pump Inhibitor Prescriptions

1. Recipients with PPI Prescriptions Before and After IRDP implemented

Date of Service	PPI Recips	No of Office Visits	Recips with Office Visits	% Recips with Office Visits	No of Inpatient Admissions	Recips with Inpatient Admissions
Jan - Sept 2001 Pre-IRDP	31,369	139,645	25,018	79.8%	9,408	6,447
Jan - Sept 2002 Post-IRDP	34,077	156,562	27,426	80.5%	10,171	7,099
Change	2,708	16,917	2,408	0.7%	763	652

2. Recipients with Prior Authorization Denial for PPI Prescriptions

Date of Prior Authorization Request	Recips	No of Office Visits	Recips with Office Visits	% Recips with Office Visits	No of Inpatient Admissions	Recips with Inpatient Admissions
Jan to Sept 2002	2,830	6,389	1,776	62.8%	356	302

Data Source: Indiana OMPP DataProbe Paid Database, Claims through 3/31/03

Prepared by
The Medstat Group

Indiana Rational Drug Program (IRDP) Evaluation
Tramadol Therapy

Executive Summary

The Indiana Medicaid Drug Utilization Review Board requested that the Office of Medicaid Policy and Planning (OMPP) develop and produce reports to evaluate the impact of the Indiana Rational Drug Program (IRDP) on the prescribing patterns for Tramadol. The evaluation has two primary objectives. One objective is to use retrospective, paid claims data to analyze the impact of the IRDP on prescribing patterns, Medicaid drug expenditures, and drug utilization. The other objective is to use retrospective, paid claims data, to the extent possible, to evaluate recipient outcomes that may be related to implementation of the IRDP.

The principal finding of the study was that the total number of prescriptions and the total expenditures for Tramadol decreased following implementation of the IRDP. Overall, there was a decrease of $1.3 million in expenditures following implementation of the IRDP.

In Calendar Year 2001, 99.99% of Tramadol prescriptions were for Ultram 50 mg. tablets. In Calendar Year 2002, Ultram prescriptions made up 38% of the total. Tramadol HCL 50 mg. tablets comprised 59% of the prescriptions and the remaining prescriptions were for Ultracet in 2002.

Another interesting finding was the large increase in the average number of prescriptions per recipient. While the average number of prescriptions per recipient increased from 3.5 to 6.6, the median increased from 2 to 3.5. This would suggest that more recipients requiring long term pain relief are receiving Tramadol.

The evaluation of outcomes was conducted for three cohorts of Medicaid enrollees. Cohort 1 included individuals for whom prior authorization for Tramadol was requested and denied and who received a substitute medication. Substitute medications include other analgesics and non-steroidal anti-inflammatory drugs (NSAIDs). Cohort 2 included individuals for whom prior authorization was denied and who did not receive a substitute medication. Cohort 3 included individuals with a prior authorization approval for whom Tramadol was dispensed.

The paid claims data was analyzed for individuals within each of the three cohorts and rates of physician office visits, emergency room visits and inpatient admissions were calculated. Valid comparisons across the cohorts cannot be made due to the large number of variables including the reason for the medical visit, co morbid conditions, other drug therapy, patient compliance and health status. Of the three cohorts, those in Cohort 1 had the highest rates of office and emergency room visits and inpatient admissions. Further study, including medical record review, is required to determine a cause and effect relationship between the Tramadol prior authorization determination and subsequent medical care.

Indiana Rational Drug Program (IRDP) Evaluation
Tramadol Therapy

Introduction

Tramadol is a centrally acting analgesic used to relieve moderate to moderately severe pain. Indications include relief of pain due to cancer or chronic joint pain. Ultram is the brand name and generic tramadol was approved by the FDA in early 2002. For the purposes of this report, generic and brand name drugs (including Ultracet, a combination of Acetaminophen and Tramadol) will be referred to as Tramadol.

Tramadol was included in the initial phase of the Indiana Rational Drug Program (IRDP) and prior authorization was required effective January 7, 2002. The purpose of this study is to evaluate the impact of the IRDP on physician prescribing patterns and patient outcomes.

A. Objectives

The Indiana Medicaid Drug Utilization Review Board requested that the Office of Medicaid Policy and Planning (OMPP) develop and produce reports to evaluate the impact of the Indiana Rational Drug Program (IRDP). The program, requiring prior authorization for specific classes of drugs, was implemented on January 7, 2002.

The evaluation has two primary objectives. One objective is to use retrospective, paid claims data to analyze the impact of the IRDP on prescribing patterns, Medicaid drug expenditures, and drug utilization. The other objective is to use retrospective, paid claims data, to the extent possible, to evaluate recipient outcomes that may be related to implementation of the IRDP.

B. Methodology

The data source is the Medstat DataProbe® Decision Support System, Indiana Medicaid paid claims database. The data include paid claims for pharmacy and medical services paid through March 31, 2003. A study design for IRDP evaluation was prepared by OMPP and presented to the DUR Board for review and approval.

The following drugs were identified as Tramadol in the paid claims data: Tramadol HCL, Ultram and Ultracet.

The time periods under study are:

Pharmacy and Medical Service Claims incurred prior to the IRDP:
1/7/01 to 12/31/01
Pharmacy and Medical Service Claims incurred following implementation of IRDP:
1/7/02 to 12/31/02

1. Utilization and Expenditure Measures

In order to evaluate changes in prescribing patterns and expenditures, the preliminary analysis included a comparison of data for drugs prescribed from January to December 2001 (prior to implementation of the IRDP) to drugs prescribed from January to December, 2002 (following implementation of the IRDP).

The following measures are included:

Number of Medicaid Enrolled Persons
Number of Prescriptions
Expenditures for Prescriptions
Unique Number of Recipients
Payments per Prescription
Payments per Recipient
Prescriptions per 1000 Enrolled Persons

The above measures are categorized by Age Group, Aid Category, Region of Residence and Totals. Authorization is granted for individuals who are 70 years of age or older with chronic pain; therefore, individuals in this age group were excluded from the study.

2. Outcomes

The DUR Board is interested in the impact that the IRDP may have on quality of care. In order to get a general idea of the utilization trends for people who were prescribed Tramadol, paid claims data for medical claims were analyzed. While the health care services may not be attributable to conditions involving Tramadol, the data provide a general picture of the utilization patterns. Variations in the patterns may raise questions for further investigation.

The health care services included in the study are physician office visits (excluding preventive services), inpatient hospital admissions, and emergency room visits. Having identified recipients of Tramadol, outcomes reports were produced by linking these recipients to medical claims incurred following the prescription.

Another component of the study is the evaluation of patient outcomes for those with a denial for Tramadol therapy through the IRDP prior authorization (PA)

program. Drug prior authorization tables are included in the DataProbe paid claims database and include a status field that enables one to determine if the prior authorization request was approved, denied or other.

The group of individuals with a PA request denial was divided into two cohorts. Cohort 1 includes individuals who had a PA request denial and were prescribed a substitute analgesic or NSAID. Cohort 2 includes individuals who had a PA request denial and were not prescribed a substitute analgesic or NSAID. Health care services incurred following a denial for Tramadol PA were identified for individuals within each cohort. Individuals for whom a PA request was approved and Tramadol was dispensed are included in Cohort 3.

C. Organization of Report

The first section of the report provides an overview of the baseline information regarding Tramadol drug utilization, including year-to-year comparisons. The second section provides an overview of the health care experience of recipients following a Tramadol prescription. Attachment A includes the detailed data from which the summaries were drawn.

II. Overview of Tramadol Prescription Data

A. Summary Prescription Rates and Expenditures

Table 1. Prescriptions per 1000 Enrolled Persons

Time Period	Tramadol Prescriptions	Enrolled Persons*	Prescriptions per 1000 Enrolled Persons	Net Payments	Payments per Prescription
Jan to Dec 2001	48,146	711,705	67.65	$2,435,639.71	$50.59
Jan to Dec 2002	16,980	748,874	22.67	$1,140,601.68	$67.17
Change	(31,166)	37,169	(44.98)	($1,295,038.03)	$16.58
Percent Change	-64. 73%	5.22%	(66.48%)	(53.17%)	32.78%

* Enrolled persons were calculated using monthly eligibility tables for State Fiscal Years 2001 and 2002. The number reflects the unique Medicaid enrollees under the age of 70, excluding RBMC members, for the time period.

Table 2. Expenditures for Tramadol prescriptions per Recipient

Time Period	Tramadol Prescriptions	Unique Recipients	Prescriptions per Recipient	Net Payments	Payments per Recipient
Jan to Dec 2001	48,146	13,731	3.51	$2,435,639.71	$177.38
Jan to Dec 2002	16,980	2,570	6.61	$1,140,601.68	$443.81
Change	(31,166)	(11,161)	3.10	($1,295,038.03)	$266.43
Percent Change	(64.73%)	(81.28%)	88.43%	(53.17%)	150.20%

Discussion

Implementation of the IRDP resulted in a significant decrease in the number of Tramadol prescriptions and corresponding expenditures. There was a 67% decrease in Tramadol prescriptions per 1000 enrollees when one compares the period January to December, 2001 (prior to IRDP) with the same dates in 2002 (following implementation of IRDP). The net annual savings was $1.3 million.

The data appear to support the finding that recipients who now receive Tramadol have longer periods of treatment and fewer individuals are receiving short term therapy. The average number of prescriptions per recipient increased by 88% following implementation of the IRDP. The median number of prescriptions per recipient increased by 75% - from 2 prescriptions per recipient to 3.5 over the annual period. These data can be found on page one of the attachment.

The Net Payments for all Tramadol prescriptions decreased by 53%. The average payment per recipient increased by 150%. This finding coincides with the increase in prescriptions per recipient from 3.5 to 6.6 across the two time periods, which is an 88% change.

Diagnoses for physician office visits by Tramadol recipients were reviewed in an attempt to understand the conditions for which the drug is being prescribed. While the office visits cannot be directly linked to the Tramadol prescriptions, conditions for which the recipients sought medical attention can be identified. The most common pain-related diagnoses for individuals who received Tramadol in Calendar Year 2002 were Lumbago, Backache, Myalgia and Myositis, Headache, Pain in Limb, Abdominal Pain, Joint Pain Left Leg, and Cervicalgia. The individuals were also seen for a wide variety of chronic and acute medical diagnoses (e.g., hypertension, diabetes, acute bronchitis).

These data include all original prescriptions and refills and do not take dosage into account. While information regarding package size, route and strength is available in the administrative data, frequency (e.g., twice daily) is not present.

Prescriptions by Drug Name

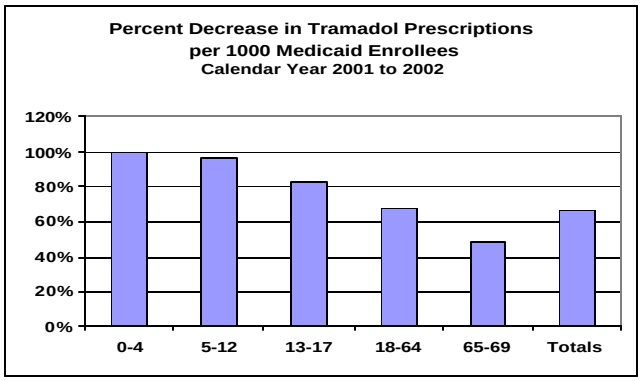
Data showing prescription patterns by drug name are found on page one of the attachment. Generic Ultram (tramadol) was not available during calendar year 2001. The generic form became available in calendar year 2002 and 59% of prescriptions containing tramadol were for the generic. Brand name Ultram was prescribed on 38% of the prescriptions in calendar year 2002. Additional data is available on page one of the attachment.

The data show an increase in payments per prescription for Ultram 50 mg. tablets from $50.60 to $75.62 across the two time periods. We are unable to determine the cause of

this 50% increase using the available paid claims data. It is possible that more tablets per prescription were dispensed in calendar year 2002. The average cost for generic Tramadol was $61.98 per prescription.

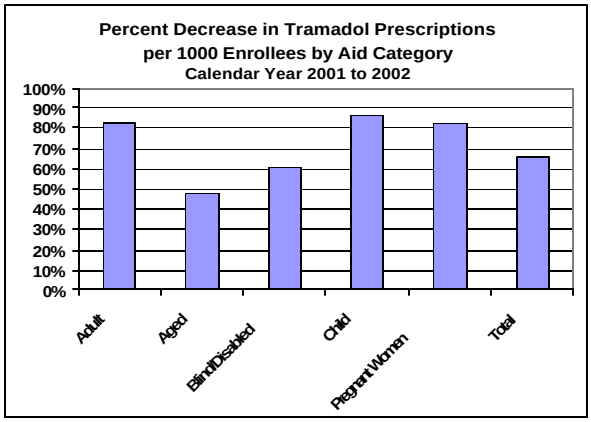
Age Group Information

The graph below illustrates the percent decrease in Tramadol prescriptions per 1000 Medicaid Enrollees from the pre-IRDP period of January to September 2001 to the post-IRDP period of January to December 2002. There was an overall decrease of 66.5%. The data shows that children under age 18 experienced the most significant decrease in number of prescriptions per 1000 enrollees.



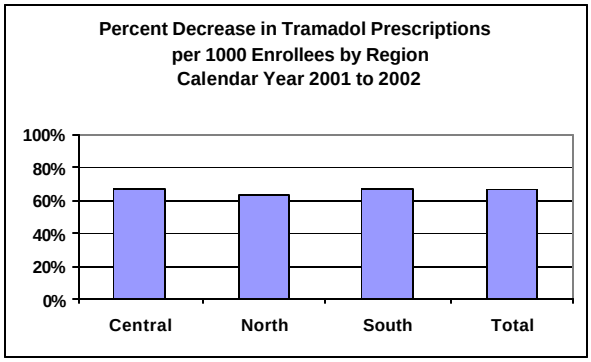
Aid Category Information

The largest decrease in prescriptions per 1000 enrollees was for the child aid category at 86% and the smallest decrease was for the aged aid category at 48%.



Region of Residence Information

The following graph indicates the percent decrease in Tramadol prescriptions per 1000 Medicaid enrollees by region of residence. The range is 63 to 68 percent.



III. Outcomes Studies

A. Introduction

Reports were produced to identify the number of inpatient admissions, physician office visits and emergency room visits experienced by recipients following a prescription for Tramadol. Due to the absence of diagnostic information on pharmaceutical claims, a cause and effect relationship between drug therapy and subsequent health care services cannot be established. The data is useful in identifying potential trends and areas of interest for further study.

Heath Care Encounter Experience for Recipients of Tramadol

The following table illustrates the findings for recipients of Tramadol, comparing pre-IRDP experience with post-IRDP experience. Individuals with Tramadol prescriptions were identified using pharmacy paid claims information. The individuals reported for Calendar year 2002 were identified from claims only and not based on an IRDP determination.

Date Tramadol Dispensed	Unique Recipients of Tramadol	% of Tramadol Recipients with Office Visit Following Prescription	% of Tramadol Recipients with Admission Following Prescription	% of Tramadol Recipients with ER Visit Following Prescription
Jan to Dec 2001 (pre-IRDP)	13,731	82.76%	19.83%	53.89%
Jan to Dec 2002 (post-IRDP)	2,570	84.01%	22.06%	47.24%
Change	(11,161)	1.25%	2.23%	(6.66%)

These rates were calculated based on all health care services, regardless of the principal diagnosis. The primary or secondary reason for the health care service may have been unrelated to the prescription or to the condition for which the drug was prescribed. The report provides a

high level picture of the utilization of these services for patients who had prescriptions for Tramadol.

Comparison of Heath Care Encounter Experience for Enrollees with Approved and Denied Prior Authorization Requests for Tramadol

In order to evaluate the potential impact of denials for prior authorization for Tramadol, an analysis of the experience of enrollees who received denials was conducted. The analysis includes data on the experience of the individuals following denial. The individuals were split into two groups. Cohort 1 includes those substitute analgesic or a non-steroidal anti-inflammatory drug (NSAID). Cohort 2 includes those who had a prior authorization denial for Tramadol and did not receive a substitute analgesic or an NSAID.

There were 850 unique individuals for whom a prior authorization request for Tramadol therapy was made and denied through the IRDP. Of these individuals, 657 received a substitute medication and 193 did not.

The following table illustrates the health care service experience of recipients with Tramadol prior authorization denials as compared to recipients who received a prior authorization appro val and to who Tramadol was dispensed (Cohort 3).

1. **Office Visits (excludes visits for preventative medicine)**

Cohort	Recipients	Number of Office Visits	Recipients with Office Visits	% Recipients with Office Visits
1 - Denied with Substitute	657	6,455	615	93.61%
2 - Denied with No Substitute	193	1,028	160	82.90%
3 - Approved with Tramadol Dispensed	2,244	12,668	1,910	85.12%

Emergency Room Visits

Cohort	Recipients	Number of ER Visits	Recipients with ER Visits	% Recipients with ER Visits
1 - Denied with Substitute	657	1,777	413	62.86%
2 - Denied with No Substitute	193	200	94	48.70%
3 - Approved with Tramadol Dispensed	2,244	2,858	1,021	45.50%

Inpatient Admissions

Cohort	Recipients	Number of Inpatient Admissions	Recipients with Inpatient Admissions	% Recipients with Inpatient Admissions
1 - Denied with Substitute	657	387	224	34.09%
2 - Denied with No Substitute	193	68	40	20.73%
3 - Approved with Tramadol Dispensed	2,244	787	491	21.88%

The data would appear to show that recipients in Cohort 1 had higher rates of office and emergency room visits and inpatient admissions than those who received Tramadol therapy and those who did not receive a substitute analgesic or an NSAID. In order to attribute outcomes to a particular prior authorization decision, a correlation between the decision and the reason for the health care encounter must be established. There are many variables that must be considered in establishing this correlation including patient age, health status, co-morbidities and the condition or disease that required intervention or management. Additional study involving medical record or detailed prior authorization data review is required to establish this relationship.

IV. Summary

The IRDP impact analysis for Tramadol found that there was a decrease in the total number of prescriptions, an increase in the number of prescriptions per recipient, and a savings of $1.3 million. While there was a decrease in the number of Tramadol prescriptions, the impact on recipients in terms of outcomes was not clearly defined.

Following are the key findings of the study:

There was a 65% decrease in prescriptions for Tramadol following implementation of the Indiana Rational Drug Program (IRDP) on January 7, 2002.

There was a 53% decrease in total Medicaid expenditures for Tramadol claims following IRDP implementation which appears to be driven by the decrease in the number of prescriptions. The program savings were $1.3 million. The average cost per prescription rose by 33%.

The average number of Tramadol prescriptions per recipient increased from 3.5 per recipient during the initial time period to 6.6 per recipient during the post IRDP time frame. The median increased from 2 prescriptions per recipient to 3.5.

The data indicate a shift to generic Tramadol following its approval in early 2002.

The data show that recipients who had a prior authorization request for Tramadol denied and who were dispensed another analgesic or an NSAID had high rates of office visits, emergency room visits and inpatient admissions. A cause and effect relationship between the medication dispensed and the rate of subsequent health care services cannot be confirmed due to the significant number of other variables. The variables include health status, co-morbid conditions, patient compliance, age, and access to care.

Tramadol has been removed from the list of drugs under the Indiana Rational Drug Program effective May 14, 2003 and is now on the Preferred Drug List.

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THOMSON MEDSTAT

Memo

From	Kate Whitaker, RN, MBA	**To**	Indiana Medicaid DUR Board
Date	July 18, 2003		
Subject	**Follow-up to Tramadol Study**		

At the May 23, 2003 meeting, OMPP presented a preliminary study evaluating the effects of the Indiana Rational Drug Program on the prescription patterns, outcomes and costs associated with the drug Tramadol. Upon review of the reports, the DUR board requested follow-up on three particular areas. The Board is interested in the timing of office visits following a prior authorization (PA) request denial for Tramadol, the inpatient admission rates of the general Indiana Medicaid population as compared to the study population and diagnoses associated with the inpatient admissions reported in the study.

1. **What was the frequency of office visits following a PA request denial for Tramadol within 30, 60 and 90 days of the determination? What are the most common diagnoses for the recipients of the office visits?**

   In order to respond to this question, Medstat queried the DataProbe decision support system and evaluated the post PA request denial medical claims for each of the two involved cohorts. Cohort 1 includes individuals who received another analgesic or non-steroidal anti-inflammatory drug (NSAID) when Tramadol therapy was denied a PA request. Cohort 2 includes individuals who did not receive another analgesic or NSAID. The recipients included in each time period are mutually exclusive. For example an individual who had a visit in the 31 to 60 day time period, did not have an office visit within 30 days of the PA determination. Following are the results of the query:

Recipients	Percent with Office Visit 30 Days after PA Request Denial	Percent with Office Visit 31 to 60 Days after PA Request Denial	Percent with Office Vis 61 to 90 Days after PA Request Denial
Cohort 1	49.3%	17.8%	26.0%
Cohort 2	36.8%	6.7%	47.2%

   The top diagnoses for office visits at each time period were analyzed for each cohort and sorted by the number of recipients with the diagnosis. The number of recipients is shown in parentheses. The results are as follows:

IRDP – Tramadol Study Follow-Up

The top diagnoses for office visits at each time period were analyzed for each cohort and sorted by the number of recipients with the diagnosis. The number of recipients is shown in parentheses. The results are as follows:

Cohort 1 – Individuals with PA Request Denial and Alternate Medication

Office Visits Within 30 days	Office Visits within 30- 60 Days	Office Visits Within 60 -90 Days
1. Diabetes Mellitus Type 2 (6)	1. Lumbago (8)	1. Diabetes Mellitus Type 2 (10)
2. Lumbago (6)	2. Diabetes Mellitus Type 2 (7)	2. Lumbago (9)
3. Hypertension (4)	3. Pain in Limb (6)	3. Acute Bronchitis (7)
4. Myalgia and Myositis (3)	4. Hypertension (5)	4. Pain in Limb (7)
5. Pain in Limb (3)	5. Acute Bronchitis (5)	5. Hypertension (6)

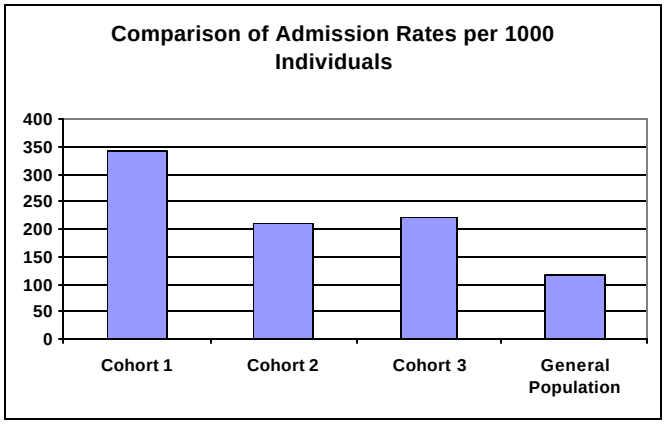
Cohort 2 – Individuals with PA Request Denial and No Alternate Medication

Office Visits Within 30 days	Office Visits within 30- 60 Days	Office Visits Within 60 -90 Days
1. Myalgia and Myositis (6)	1. Benign Hypertension (1)	1. Myalgia and Myositis (5)
2. Esophageal Reflux (3)	2. Diabetes Mellitus Type 2 (1)	2. Acute Sinusitis (4)
3. Viral Infection (2)	3. Joint Pain – Ankle (1)	3. Lumbago (4)
4. Benign Hypertension (2)	4. Cervical Spondylosis (1)	4. Acute Pharyngitis (3)
5. Hypertension (2)	5. Pain in Thoracic Spine (1)	5. Acute Bronchitis (3)

Diagnoses involving painful conditions appear in the top 5 diagnoses for all sets of office visit data. Also included are a variety of other diseases and conditions that are most likely unrelated to a Tramadol prescription or denial of a PA request for the drug.

How do the admission rates of the three cohorts compare to the general Indiana Medicaid Population?

In order to produce the most valid comparison, the general Medicaid population was subset to exclude risk-based managed care (RBMC) members as was done for the purposes of the Tramadol study. For the same reason, the population was further limited to those under 70 years of age. The data showed that individuals who received Tramadol or a PA request denial for Tramadol had higher admission rates than the general population. The rate for admissions for the general, non RBMC Medicaid population was 114.4 admissions per thousand eligible persons. Individuals who had a denial for Tramadol and received an alternative medication had the highest rate of admissions at 341 per thousand individuals in the cohort. Cohort 3 includes individuals who received a PA approval for Tramadol therapy.



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IRDP – Tramadol Study Follow-Up

3. What are the top diagnoses associated with admissions for each cohort identified in the Tramadol study?

The top discharge diagnoses for these individuals were as follows:

Rank	Cohort 1 – Denied PA for Tramadol with Other Analgesic Prescription or NSAID	Cohort 2 – Denied PA for Tramadol without Analgesic or NSAID Prescription	Cohort 3 – Approved PA for Tramadol
1	Abdominal Pain (22)	Chest Pain (5)	Chest Pain (62)
2	Chest Pain (21)	Obstr. Chronic Bronchitis (4)	Pneumonia (45)
3	Pneumonia (16)	Pneumonia (3)	Abdominal Pain (31)
4	Congestive Heart Failure (9)	Septicemia (2)	Congestive Heart Failure (30)
5	Obstructive Chronic Bronchitis (9)	Bipolar Affective (2)	Obstr. Chronic Bronch (30)
6	Intermed Coronary Syndrome (7)	Congestive Heart Failure (2)	Shortness of Breath (22)
7	Acute Pancreatitis (7)	Acute Respiratory Failure (2)	Depressive Psych – Unspec (16)
8	Hypovolemia (7)	Lumbar Disc Displacement (2)	Intermed Coronary Syndrome (16)
9	Abdominal Pain Epigastric (7)	Nausea with Vomiting (2)	Nausea with Vomiting (15)
10	Depressive Psych – Unspec (6)	Abdominal Pain (2)	Cellulitis of Leg (14)

The top diagnoses for the general non-RBMC Medicaid population are pregnancy and delivery-related, pneumonia, chestpain, fever, hypovolemia and abdominal pain.

Indiana Rational Drug Program (IRDP) Evaluation
Synagis® and Respigam® Therapy

Executive Summary

The Indiana Medicaid Drug Utilization Review Board requested that the Office of Medicaid Policy and Planning (OMPP) develop and produce reports to evaluate the impact of the Indiana Rational Drug Program (IRDP) on the prescribing patterns of Synagis and Respigam for Respiratory Syncytial Virus (RSV). The drugs were placed on the IRDP on April 15, 2002.

The evaluation has two primary objectives. One objective is to use retrospective, paid claims data to analyze the impact of the IRDP on prescribing patterns, Medicaid drug expenditures, and drug utilization. The other objective is to use retrospective, paid claims data, to the extent possible, to evaluate recipient outcomes that may be related to implementation of the IRDP.

Because the IRDP documentation indicates that treatment can only be approved during the RSV season and that the approval period is October 15 through April 30 of the next year, this time period was used for the analysis. Prescriptions were identified as those dispensed between October 15 and April 30 of the next year.

No prescriptions for Respigam were identified in the data, therefore, the study focused on Synagis. The principal finding of the study was that expenditures for the drug decreased by $1.6 million. The number of unique recipients of the drug decreased by nearly 50% and the rate of prescriptions per thousand enrollees decreased by 47%. Review of the medical claims data did not reveal any apparent negative impact on the outcomes to Medicaid enrollees who did not receive a prior authorization approval.

Indiana Rational Drug Program (IRDP) Evaluation
Synagis Therapy

Introduction

A. Objectives

The Indiana Medicaid Drug Utilization Review Board requested that the Office of Medicaid Policy and Planning (OMPP) develop and produce reports to evaluate the impact of the Indiana Rational Drug Program (IRDP). The program, requiring prior authorization for specific classes of drugs, was implemented on January 7, 2002. Drugs were phased into the program over time. Synagis was placed on the program effective April 15, 2002.

The evaluation has two primary objectives. One objective is to use retrospective, paid claims data to analyze the impact of the IRDP on prescribing patterns, Medicaid drug expenditures, and drug utilization. The other objective is to use retrospective, paid claims data, to the extent possible, to evaluate recipient outcomes that may be related to implementation of the IRDP.

B. Methodology

The data source is the Medstat DataProbe® Decision Support System, Indiana Medicaid paid claims database. The time periods evaluated for the study of Synagis aredispensed dates from October 2001 to March 2002 (RSV season prior to IRDP) and October 2002 to March 2003 (RSV season following implementation of the IRDP). The month of April could not be included, as the database did not contain claims paid after March 31, 2003.

1. Utilization and Expenditure Measures

In order to evaluate changes in prescribing patterns and expenditures, the preliminary analysis includes a comparison of data regarding drugs prescribed from the 2002 RSV season to the 2003 RSV Season.

The following measures are included:

Number of Medicaid Eligible Persons (Children aged 2 and under)
Number of Prescriptions
Expenditures for Prescriptions
Unique Number of Recipients
Payments per Prescription
Payments per Recipient
Prescriptions per 1000 Eligible Persons

The above measures are categorized by Age Group, Region of Residence and Totals. Synagis is primarily prescribed to children aged two and under who are at risk for Respiratory Syncytial Virus (RSV).

IRDP Evaluation -- Synagis

2. Outcomes

The DUR Board is interested in the impact that the IRDP may have on quality of care. In order to get a general idea of the outcomes for people prescribed IRDP drugs, paid claims data for medical claims were also analyzed. For the purposes of this study, health care services with the diagnosis of RSV are of particular interest, especially inpatient hospitalizations.

The health care services included in the study are physician office visits (excluding preventive services), inpatient hospital admissions, and emergency room visits. Having identified recipients of Synagis, outcomes reports were produced by linking these recipients to medical claims incurred following the prescription where the primary or secondary diagnosis was RSV.

Another component of the study is the evaluation of patient outcomes for those with a denial for Synagis therapy through the IRDP prior authorization (PA) program. Health care encounters were identified for individuals with a denied PA request for Synagis. Of the total number of prior authorization requests, 7.3% were denied.

C. Organization of Report

The first section of the report provides an overview of the baseline information regarding Synagis utilization, including year-to-year comparisons. The second section provides an overview of the health care experience of recipients following a Synagis prescription. Attachment A includes the detailed data from which the summaries were drawn.

II. Overview of Synagis Prescription Data

A. Summary Prescription Rates and Expenditures

1. Prescriptions per 1000 Eligible Persons

Time Period	Tramadol Prescriptions	Enrolled Persons*	Prescriptions per 1000 Enrolled Persons	Net Payments	Payments per Prescription
Jan to Dec 2001	48,146	711,705	67.65	$2,435,639.71	$50.59
Jan to Dec 2002	16,980	748,874	22.67	$1,140,601.68	$67.17
Change	(31,166)	37,169	(44.98)	($1,295,038.03)	$16.58
Percent Change	-64.73%	5.22%	(66.48%)	(53.17%)	32.78%

* Unique enrollees were calculated using monthly eligibility tables for State Fiscal Years 2002 and 2003 and include only children aged 2 and under. The number reflects the unique Medicaid enrollees, excluding RBMC members, for the time period.

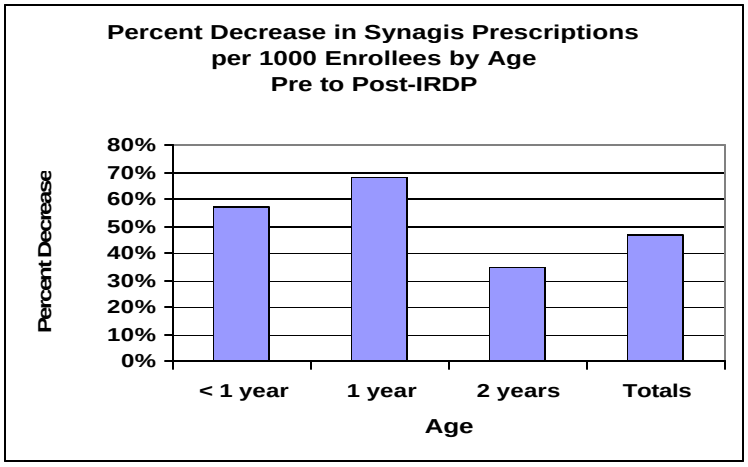
2. Expenditures for Synagis prescriptions per Recipient

Time Period	Synagis Prescriptions	Unique Recipients	Prescriptions per Recipient	Net Payments	Payments per Recipient
Apr to Dec 2001	3,040	612	4.97	$2,992,763	$4,890
Apr to Dec 2002	1,237	308	4.02	$1,366,413	$4,436
Change	(1,803)	(304)	(0.95)	($1,626,350)	($454)
Percent Change	(59.3%)	(49.7%)	(19.1%)	(54.3%)	(9.3%)

Discussion

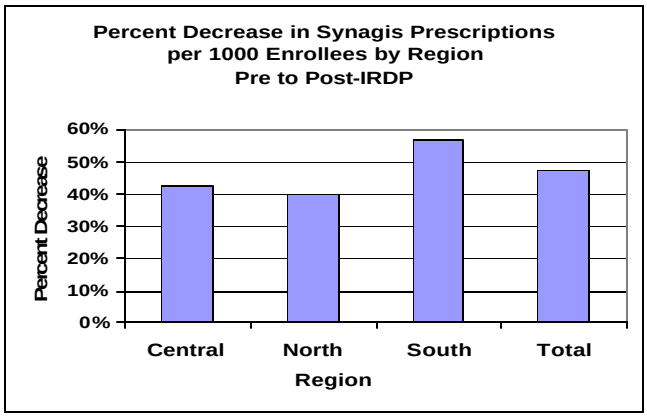
There was a 59.3% decrease in Synagis prescriptions when comparing the period October 2001 to March 2002 with the same dates ending in 2003. The Net Payments for all Synagis prescriptions decreased by $1.6 million or 54.3%. Payments per prescription increased by 19.1% and payments per recipient decreased by 9.3%. These data include all original prescriptions and refills.

Age Group Information



The graph above illustrates the percent decrease in Synagis prescriptions per 1000 `Medicaid Enrollees from the pre-IRDP period of October 2001 to March 2002 to the post-IRDP period of October 2002 to March 2003. One year olds experienced the largest decrease in Synagis prescriptions per enrollee at 68%. Two year olds had the smallest decrease at 36%.

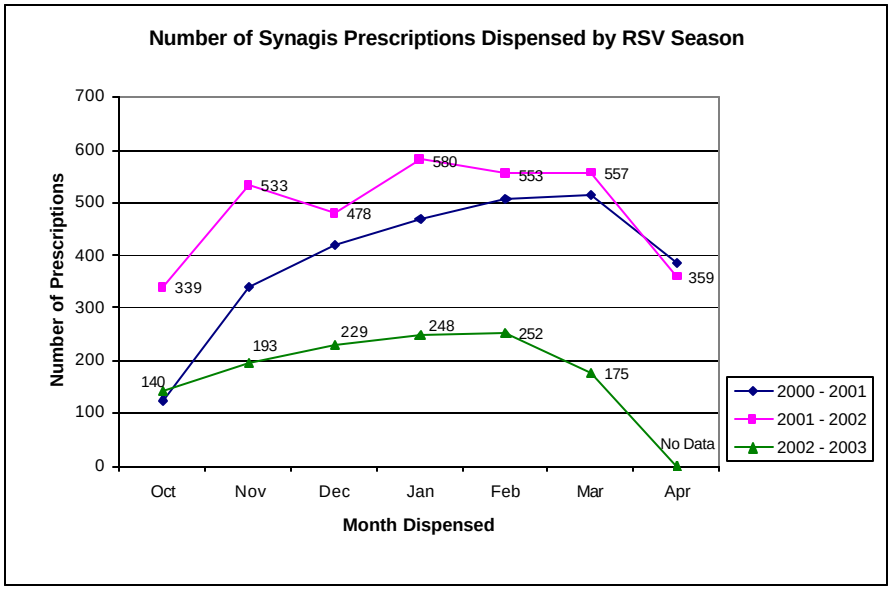
Region of Residence Information



The South Region had the largest decrease in Synagis prescriptions per 1000 Medicaid eligibles aged 2 and under at 57%. The decrease for the Central and North regions was nearly the same at 41 and 40 percent respectively.

D. Seasonal Comparison

Synagis is indicated as a preventative measure for children at high risk for developing RSV, which is primarily a seasonal disease. The data were analyzed in terms of the number of Synagis prescriptions dispensed during the months of October to April in three annual time periods. The results indicate a large decrease in the number of prescriptions per month from the time period ending in April 2001 to the time period ending in March 2003. The month of April 2003 could not be shown as the database is currently updated to claims paid as of March 31, 2003.



III. Outcomes Studies

A. Introduction

Reports were produced to identify the number of inpatient admissions, physician office visits and emergency room visits experienced by recipients following a prescription for Synagis.

Heath Care Encounter Experience for Recipients of Synagis

The following table illustrates the findings for recipients of Synagis, comparing pre-IRDP experience with post-IRDP experience. The office visits, inpatient admissions and ER visits include only those where RSV was the primary or secondary diagnosis. Health care services include those incurred within 60 days from the date the Synagis was dispensed.

Date Synagis Dispensed	Unique Recipients of Synagis	% of Synagis Recipients with Office Visit Following Prescription	% of Synagis Recipients with Admission Following Prescription	% of Synagis Recipients with ER Visit Following Prescription
Oct 01 to Mar 02 (pre-IRDP)	612	2.8%	1.0%	0.5%
Oct 02 to Mar 03 (post-IRDP)	308	0.6%	0.0%	0.0%
Change	(304)	(2.1%)	(1.0%)	(0.5%)

Comparison of Heath Care Encounter Experience for Enrollees with Approved and Denied Prior Authorization Requests for Synagis

In order to evaluate the potential impact of denials for prior authorization for Synagis, an analysis of the experience of enrollees who received denials was conducted. There were 65 unique individuals for whom a prior authorization request for Synagis was made and denied through the IRDP.

The following table compares the health care encounter experience of individuals to whom Synagis was dispensed following implementation of the IRDP to those who were denied prior authorization for Synagis.

Synagis Status	Unique Enrollees	% Enrollees with Office Visit	% Enrollees with Admission	% Enrollees with ER Visit
Dispensed Oct 02 to Mar 03	308	0.6%	0.0%	0.0%
Prior Authorization Denied	65	0.0%	0.0%	0.0%

Neither group had any admissions nor emergency room visits with a diagnosis of RSV following the prior authorization determination. Individuals who received Synagis had office visits at a rate of 0.6% within 60 days following receipt of the medication.

IV. Summary

The IRDP impact analysis for Synagis found that there was a decrease in the total number of prescriptions, a decrease in the number of prescriptions per recipient, and a savings of $1.6 million. While there was a decrease in the number of Synagis prescriptions, there appeared to be no impact on recipients in terms of adverse outcomes. Because the study is limited to paid claims data, outcomes cannot be fully evaluated.

Following are the key findings of the study:

There was a 59% decrease in prescriptions for Synagis following its inclusion in the Indiana Rational Drug Program (IRDP) on April 15, 2002.
There was a 54% decrease in total Medicaid expenditures for Synagis following IRDP implementation, which appears to be driven by the decrease in the number of prescriptions. The program savings were $1.6 million. The average cost per prescription rose by $120, which is 12% increase.
The number of Synagis prescriptions per recipient decreased from 5 per recipient during the initial time period to 4 per recipient during the post IRDP time frame.
Enrollees who were denied a prior authorization request for Synagis did not have any inpatient admissions, emergency room visits or office visits with a diagnosis of RSV within 60 days of the determination.

Summary Statistics for Synagis Prescriptions

RBMC Members are excluded.

Date Dispensed	Unique Enrollees Age <= 2 yrs	Synagis Prescriptions	Unique Recipients	Prescriptions per 1000 Enrolles	Net Payments	Average Pmt per Prescription	Pmt per Recipient
Oct 2001 to March 2002	105,340	3,040	612	28.86	$2,992,763	$984	$4,890
Oct 2003 to March 2003	81,302	1,237	308	15.21	$1,366,413	$1,105	$4,436
Change	-24,038	-1,803	-304	-13.64	-$1,626,350	$120	-$454
Percent Change	-22.8%	-59.3%	-49.7%	-47.3%	-54.3%	12.2%	-9.3%

Data Source: Indiana OMPP DataProbe Paid Database, Claims through 3/31/03

Number of Synagis Prescriptions Dispensed by RSV Season

Paid Claims Data for April 2003 Unavailable

	Number of Prescriptions		
Month Dispensed	2000-2001	2001-2002	2002-2003
Oct	117	328	140
Nov	323	515	193
Dec	395	453	229
Jan	437	544	248
Feb	461	519	252
Mar	481	518	175
Apr	365	316	NA

Data Source: Indiana OMPP DataProbe Paid Database, Claims through 3/31/03

Statistics for Synagis Prescriptions by Age Group

1. Prescriptions (Scripts) per 1000 Enrollees

	October 2001 to March 2002			October 2001 to March 2002			Scripts per 1000 Enrollees	
Age In Years	Prescriptions	Enrollment	Scripts per 1000 Enrollees	Prescriptions	Enrollment	Scripts per 1000 Enrollees	Change	Percent Change
Under 1	1,947	46,676	53.9	839	36,126	23.2	-30.7	-56.9%
1	952	40,991	30.3	307	31,435	9.8	-20.5	-67.8%
2	141	36,701	4.9	91	29,002	3.1	-1.7	-35.5%
Totals	**3,040**	**105,340**	**28.9**	**1,237**	**81,302**	**15.2**	**-13.6**	**-47.3%**

2. Prescriptions per Recipient by Age in Years

	October 2001 to March 2002			October 2001 to March 2002			Prescriptions per Recipient	
Age In Years	Prescriptions	Unique Recipients	Prescriptions per Recipient	Prescriptions	Unique Recipients	Prescriptions	Change	Percent Change
Under 1	1,947	480	4.1	839	245	3.4	-0.6	-15.6%
1	952	185	5.1	307	75	4.1	-1.1	-20.5%
2	141	31	4.5	91	15	6.1	1.5	33.4%
Totals	**3,040**	**612**	**5.0**	**1,237**	**308**	**4.0**	**-1.0**	**-19.1%**

Data Source: Indiana OMPP DataProbe Paid Database, Claims through 3/31/03

3. Expenditures per Recipient

	October 2001 to March 2002			October 2001 to March 2002			Expenditures per Recipient	
Age In Years	Expenditures	Unique Recipients	Expenditures per Recipient	Expenditures	Unique Recipients	Expenditures per Recipient	Change	Percent Change
Under 1	$1,724,768	480	$3,593	$846,929	245	$3,457	-136.4	-3.8%
1	$1,075,281	185	$5,812	$371,038	75	$4,947	-865.2	-14.9%
2	$192,714	31	$6,217	$148,445	15	$9,896	3679.8	59.2%
Totals	**$2,992,763**	**612**	**$4,890**	**$1,366,412**	**308**	**$4,436**	**-453.7**	**-9.3%**

Data Source: Indiana OMPP DataProbe Paid Database, Claims through 3/31/03

Statistics for Synagis Prescriptions by Region of Residence

1. Prescriptions (Scripts) per 1000 Enrollees

	October 2001 to March 2002			October 2002 to March 2003			Scripts per 1000 Enrollees	
Region	Prescriptions	Enrollment	Scripts per 1000 Enrollees	Prescriptions	Enrollment	Scripts per 1000 Enrollees	Change in scripts/ 1000	Percent Change
Central	991	40,400	24.5	463	32,934	14.1	-10.5	-42.7%
North	1,186	37,862	31.3	415	22,105	18.8	-12.6	-40.1%
South	863	27,078	31.9	359	26,263	13.7	-18.2	-57.1%
Total	**3,040**	**105,340**	**28.9**	**1,237**	**81,302**	**15.2**	**-13.6**	**-47.3%**

2. Prescriptions per Recipient

	October 2001 to March 2002			October 2002 to March 2003			Prescriptions per Recipient	
Region	Prescriptions	Unique Recipients	Prescriptions per Recipient	Prescriptions	Unique Recipients	Prescriptions per Recipient	Change	Percent Change
Central	991	200	5.0	463	108	4.3	-0.67	-13.5%
North	1,186	235	5.0	415	109	3.8	-1.24	-24.6%
South	863	180	4.8	359	91	3.9	-0.85	-17.7%
Total	**3,040**	**612**	**5.0**	**1,237**	**308**	**4.0**	**-0.95**	**-19.1%**

Data Source: Indiana OMPP DataProbe Paid Database, Claims through 3/31/03

3. Expenditures per Recipient

	April to December 2001			April to December 2002			Expenditures per Recipient	
Region	Expenditures	Unique Recipients	Expenditures per Recipient	Expenditures	Unique Recipients	Expenditures per Recipient	Change	Percent Change
Central	$993,624	200	$4,968.12	$488,271	108	$4,521.02	-$447.10	-9.00%
North	$1,157,225	235	$4,924.36	$444,223	109	$4,075.44	-$848.92	-17.24%
South	$841,914	180	$4,677.30	$433,919	91	$4,768.34	$91.04	1.95%
Total	**$2,992,763**	**612**	**$4,890.14**	**$1,366,412**	**308**	**$4,436.40**	**-$453.73**	**-9.28%**

Data Source: Indiana OMPP DataProbe Paid Database, Claims through 3/31/03

Outcome Statistics for Synagis

1. Recipients with Synagis Prescriptions Before and After IRDP implemented

Date of Service	Synagis Recips	No of Office Visits	Recips with Office Visits	% Recips with Office Visits	No of Inpatient Admissions	Recips with Inpatient Admissions	% Recips with Inpatient Admissions	No of ER Visits	Recips with ER Visits	% Recips with ER Visits
Oct 01 to Mar 02 Pre IRDP	612	21	17	2.8%	6	6	1.0%	3	3	0.5%
Oct 02 to Mar 03 Post IRDP	308	3	2	0.6%	0	0	0.0%	0	0	0.0%
Change	**-304**	**-18**	**-15**	**-2.1%**	**-6**	**-6**	**-1.0%**	**-3**	**-3**	**-0.5%**

2. Recipients with Prior Authorization Denial for Synagis

Date of Prior Authorization Request	Recips	No of Office Visits	Recips with Office Visits	% Recips with Office Visits	No of Inpatient Admissions	Recips with Inpatient Admissions	% Recips with Inpatient Admissions	No of ER Visits	Recips with ER Visits	% Recips with ER Visits
Oct 2002 to March 2003	65	0	0	0.0%	0	0	0.0%	0	0	0.0%

Data Source: Indiana OMPP DataProbe Paid Database, Claims through 3/31/03

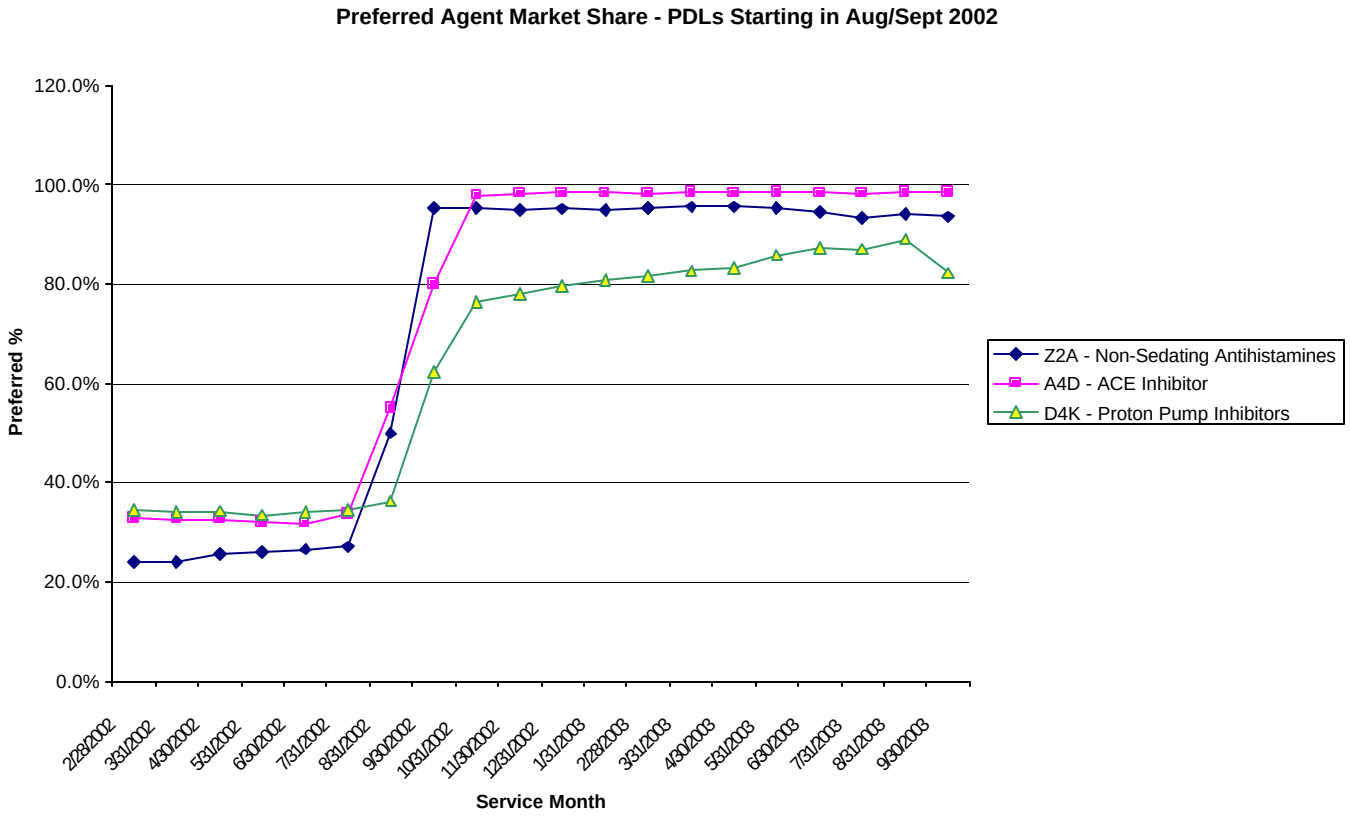
ATTACHMENT 6.3.A PDL PROGRAM ESTIMATED SAVINGS ANALYSES

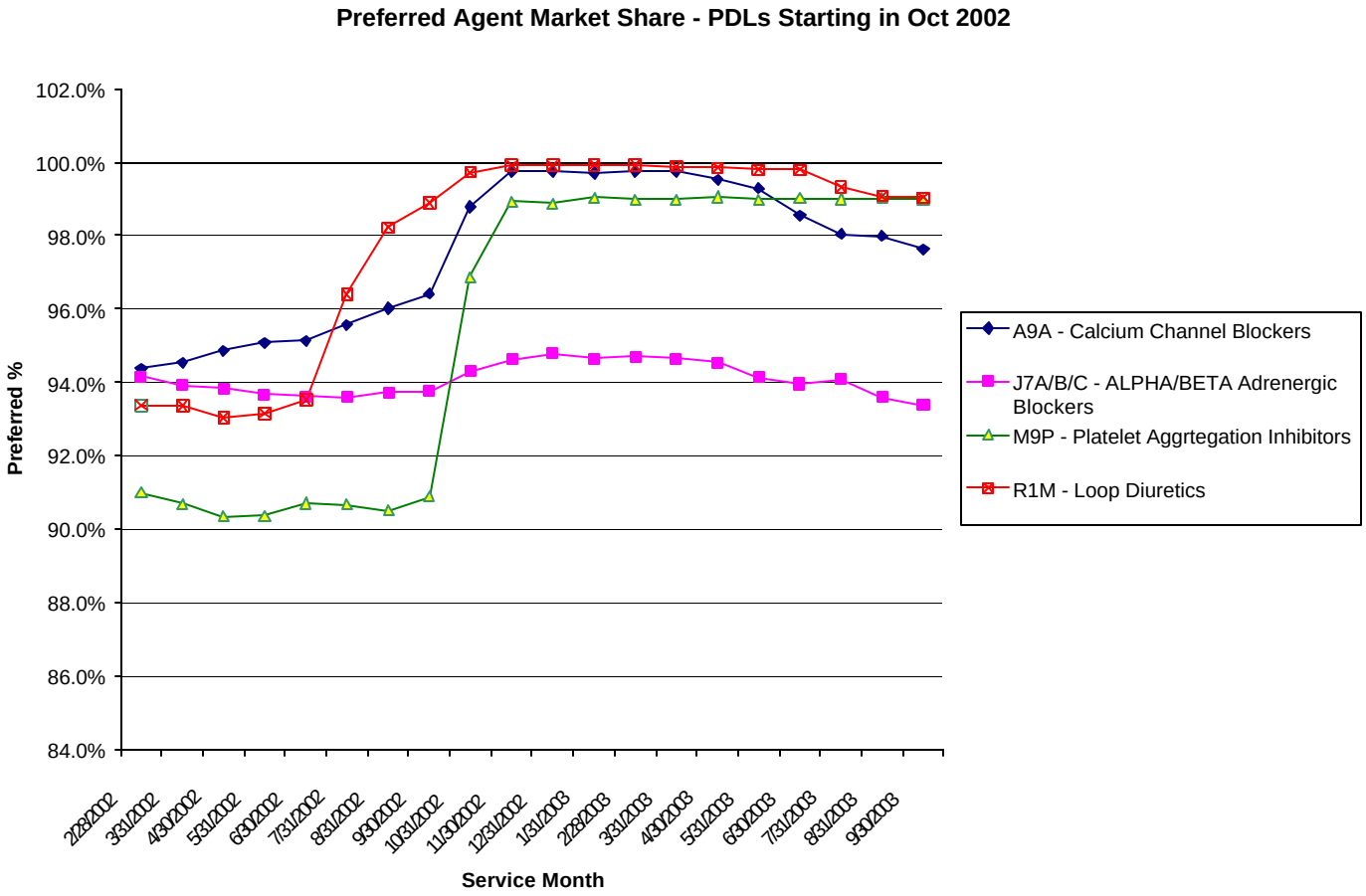
GRAND TOTAL ANNUALIZED PREFERRED DRUG LIST (PDL) PROGRAM SAVINGS
(Payment, Rebate Amounts, & Net Savings)

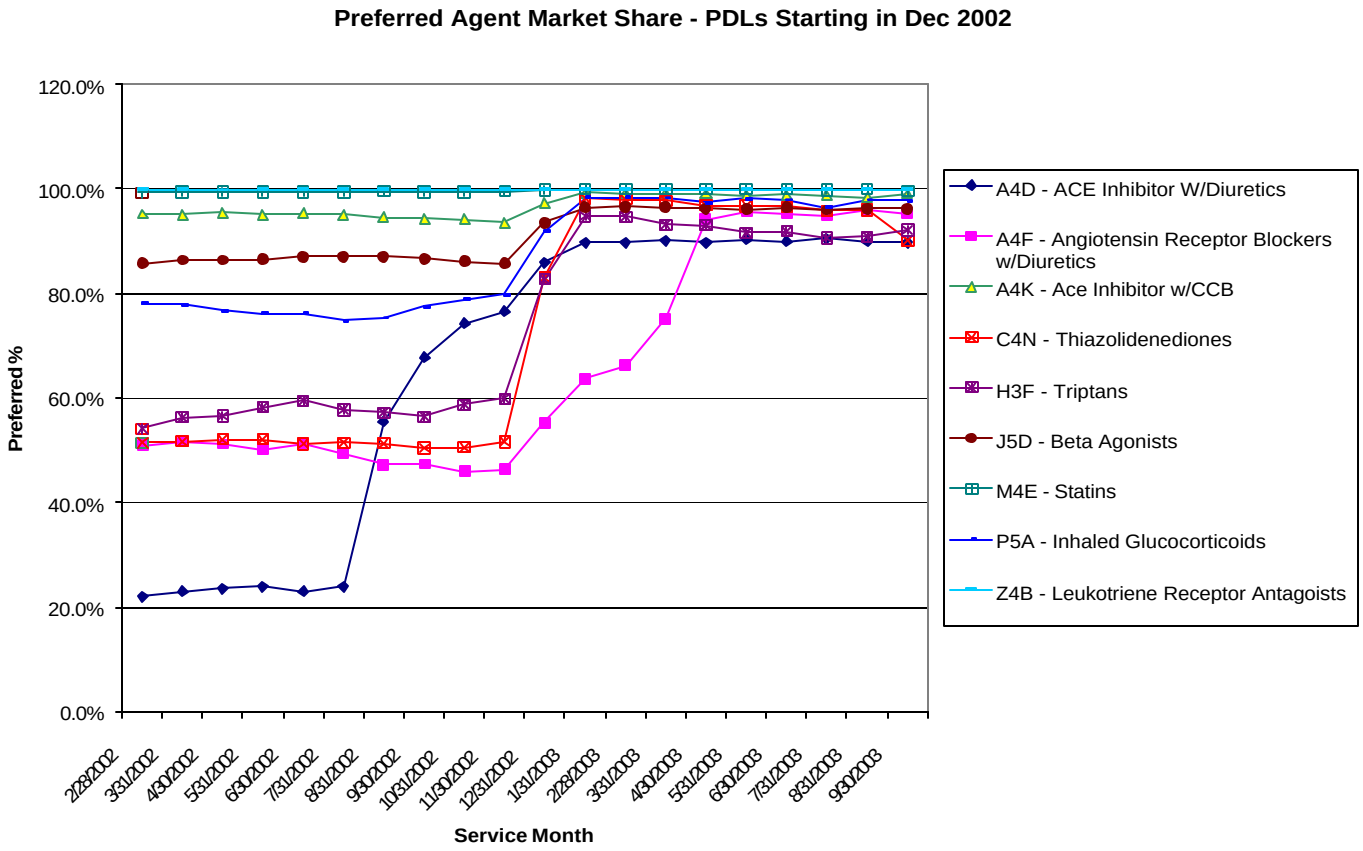
									% Market Share Before PDL
	TOTAL PDL PROGRAMS	**$ 12,434,379**	-3,524,829.19	**$ 8,909,550**	4,936,501	$270,872,141	$ 70,104,418	$200,767,723	74.3%
	Classes With Limited Potential	-136,883.39	-571,946.08	-708,829.47	2,360,481	$115,967,894	$ 29,425,857	$ 86,542,036	98.9%
	Totals for Classes With Potential To Impact	$ 12,571,262	-2,952,883.12	$ 9,618,379	2,576,019	$154,904,247	$ 40,678,561	$114,225,687	64.3%
	Classes With Limited Potential for Change:								
	* Classes with no non-preferred drugs								
	** Classes with no preferred drugs								
	*** Classes with preferred drugs having more than 95 percent of market share at program start								
	**** Classes with too low volume or too short of an operational period to be evaluated								
52	Total Classes								
2	Classes w/ too short operational period to evaluate								
2	Classes all Non-Preferred (Impact in PA Program)								
18	asses w/ Limited Potential to Change (All or >95% preferred at start)								
30	# Classes With Potential to Impact								
5 of 30	5 of 30 Classes >90% Preferred at Start								

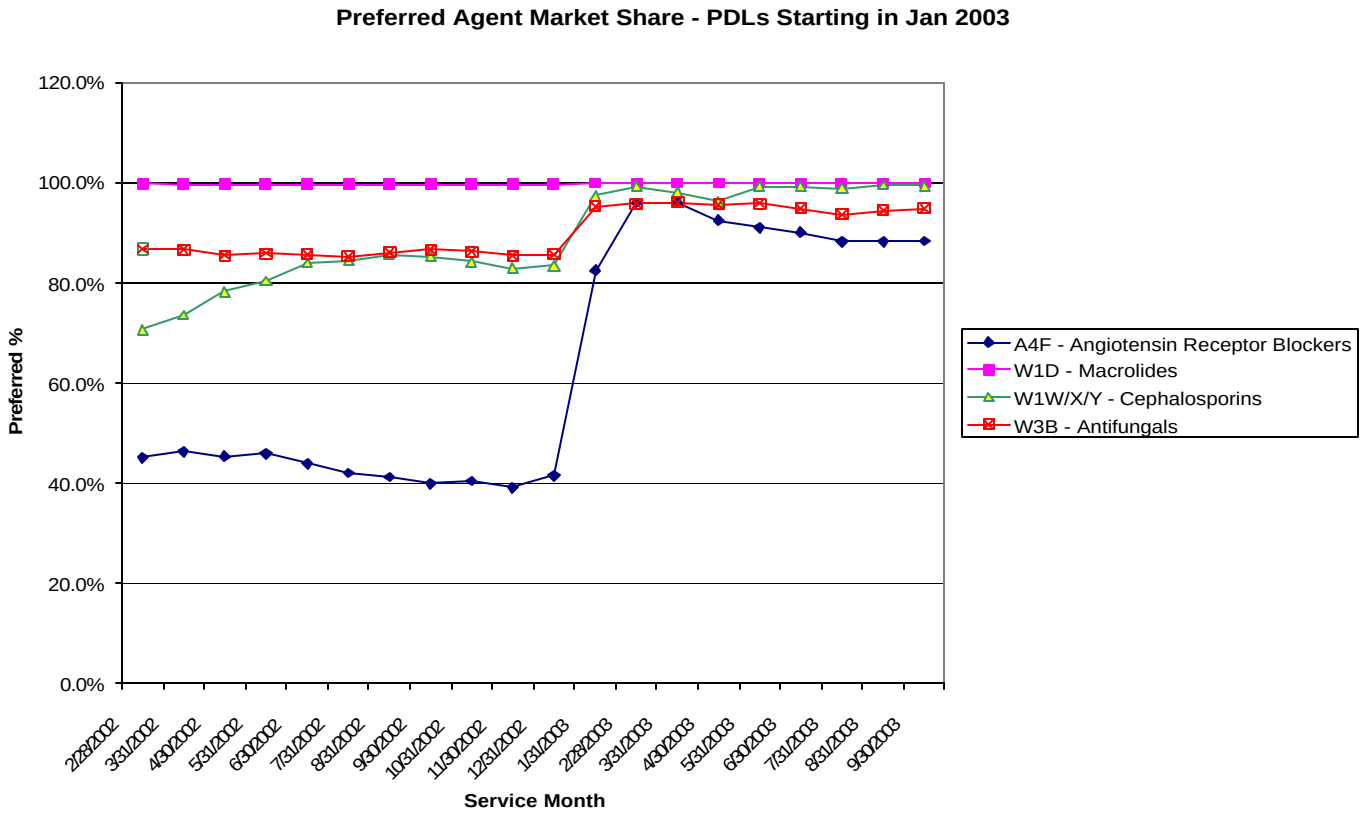
ATTACHMENT 6.3.B PREFERRED DRUG LIST (PDL) PROGRAM UTILIZATION TRENDS:

PERCENT PREFERRED PER PDL CATEGORY

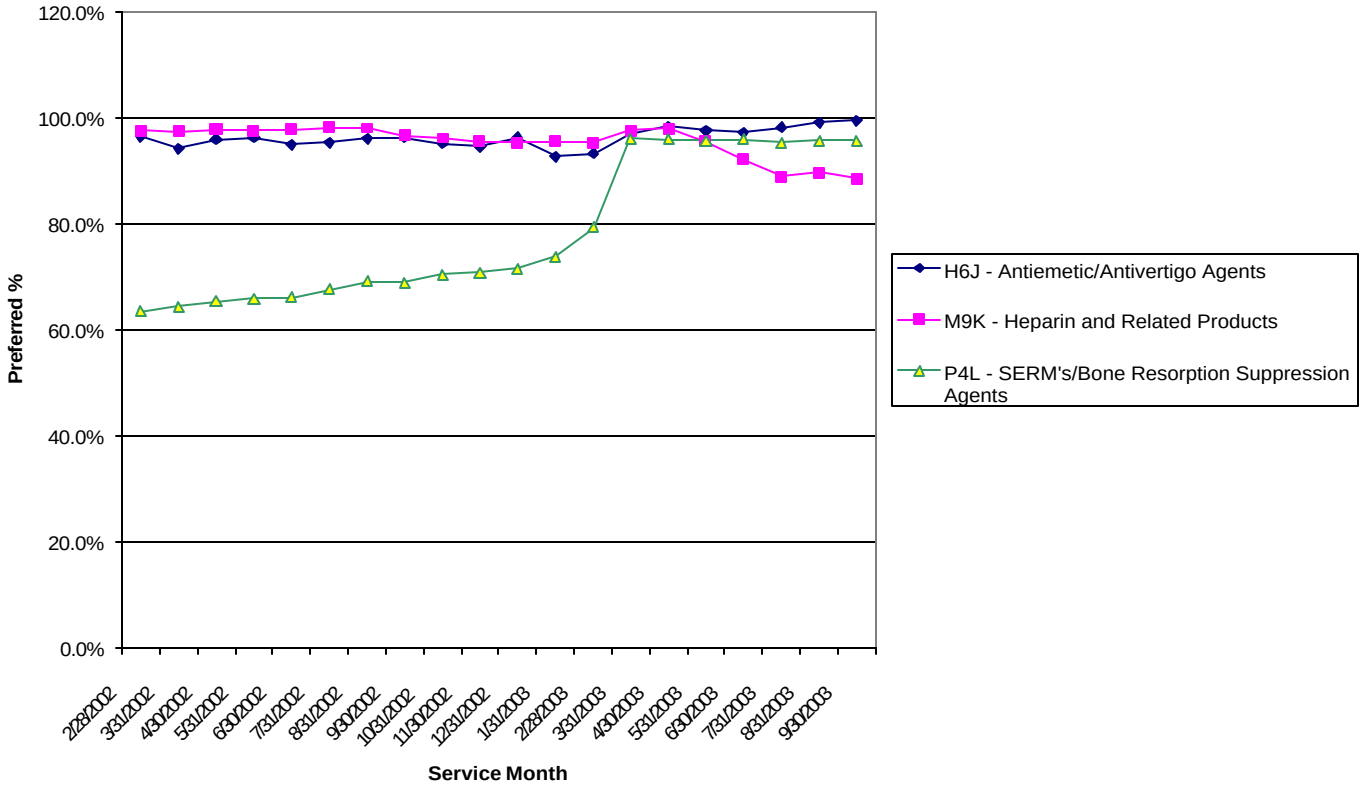


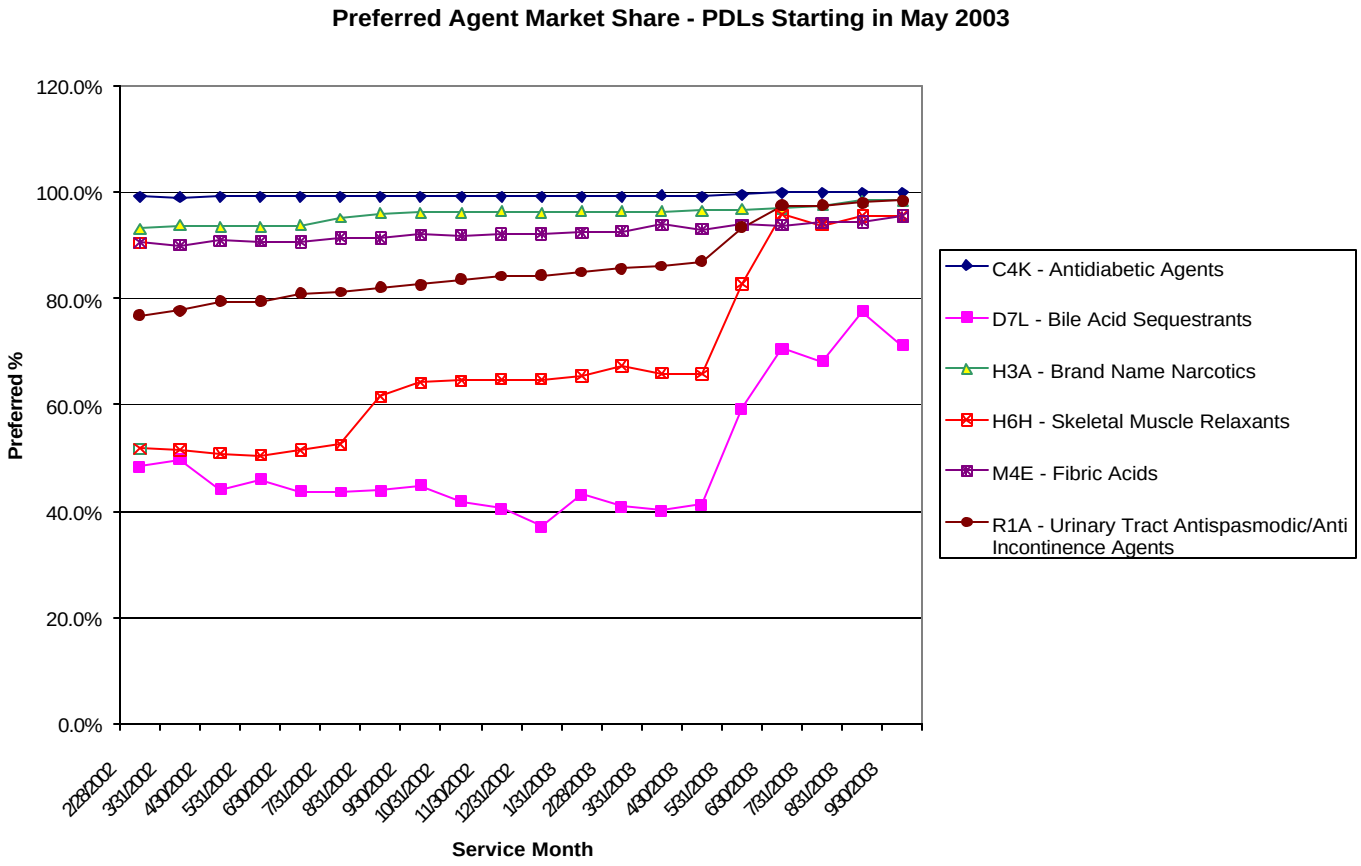

Preferred Agent Market Share - PDLs Starting in Oct 2002
102.0%
100.0%
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
Preferred %
2/28/2002
3/31/2002
4/30/2002
5/31/2002
6/30/2002
7/31/2002
8/31/2002
9/30/2002
10/31/2002
11/30/2002
12/31/2002
1/31/2003
2/28/2003
3/31/2003
4/30/2003
5/31/2003
6/30/2003
7/31/2003
8/31/2003
9/30/2003
Service Month
A9A - Calcium Channel Blockers
J7A/B/C - ALPHA/BETA Adrenergic Blockers
M9P - Platelet Aggrtegation Inhibitors
R1M - Loop Diuretics

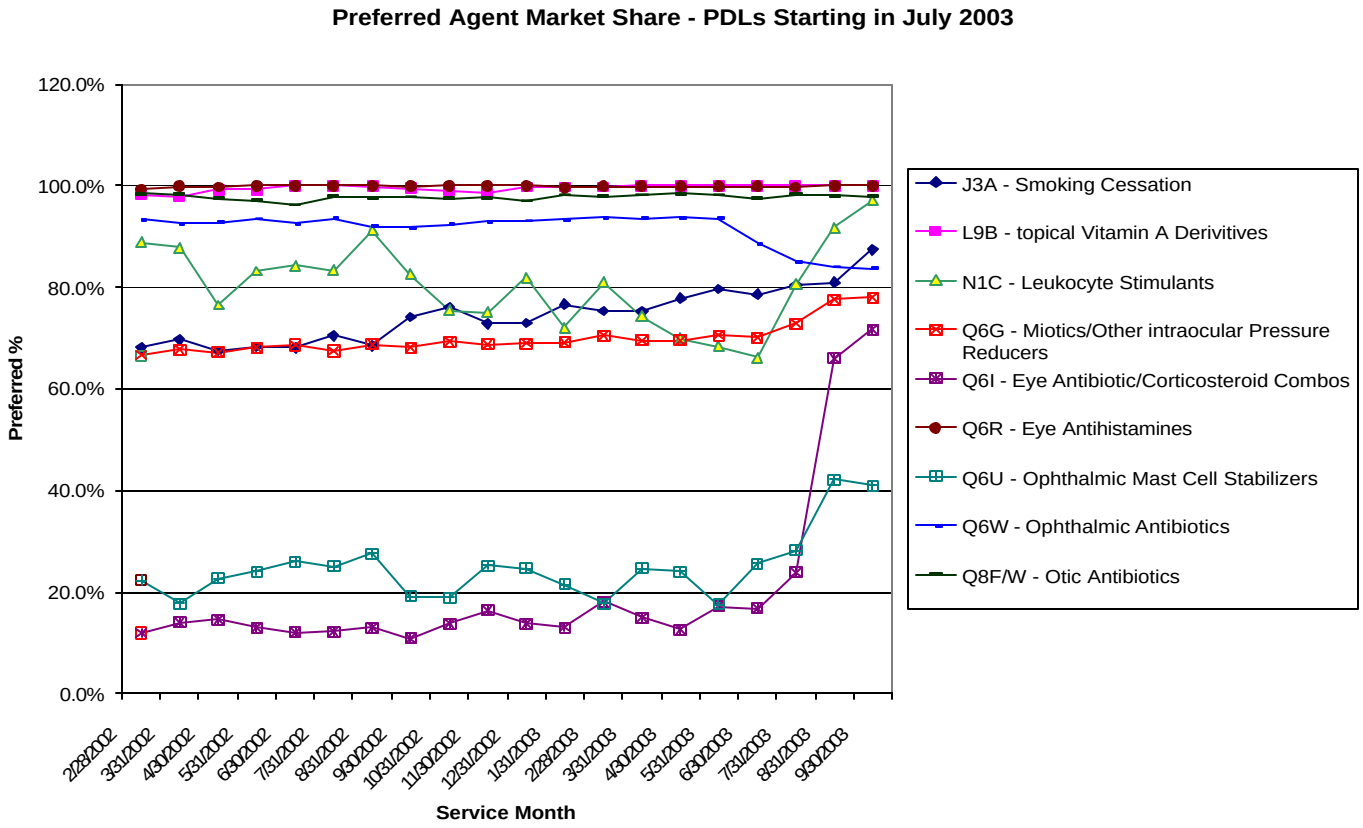

Preferred Agent Market Share - PDLs Starting in Dec 2002
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Preferred %
2/28/2002
3/31/2002
4/30/2002
5/31/2002
6/30/2002
7/31/2002
8/31/2002
9/30/2002
10/31/2002
11/30/2002
12/31/2002
1/31/2003
2/28/2003
3/31/2003
4/30/2003
5/31/2003
6/30/2003
7/31/2003
8/31/2003
9/30/2003
Service Month
A4D - ACE Inhibitor W/Diuretics
A4F - Angiotensin Receptor Blockers w/Diuretics
A4K - Ace Inhibitor w/CCB
C4N - Thiazolidenediones
H3F - Triptans
J5D - Beta Agonists
M4E - Statins
P5A - Inhaled Glucocorticoids
Z4B - Leukotriene Receptor Antagoists

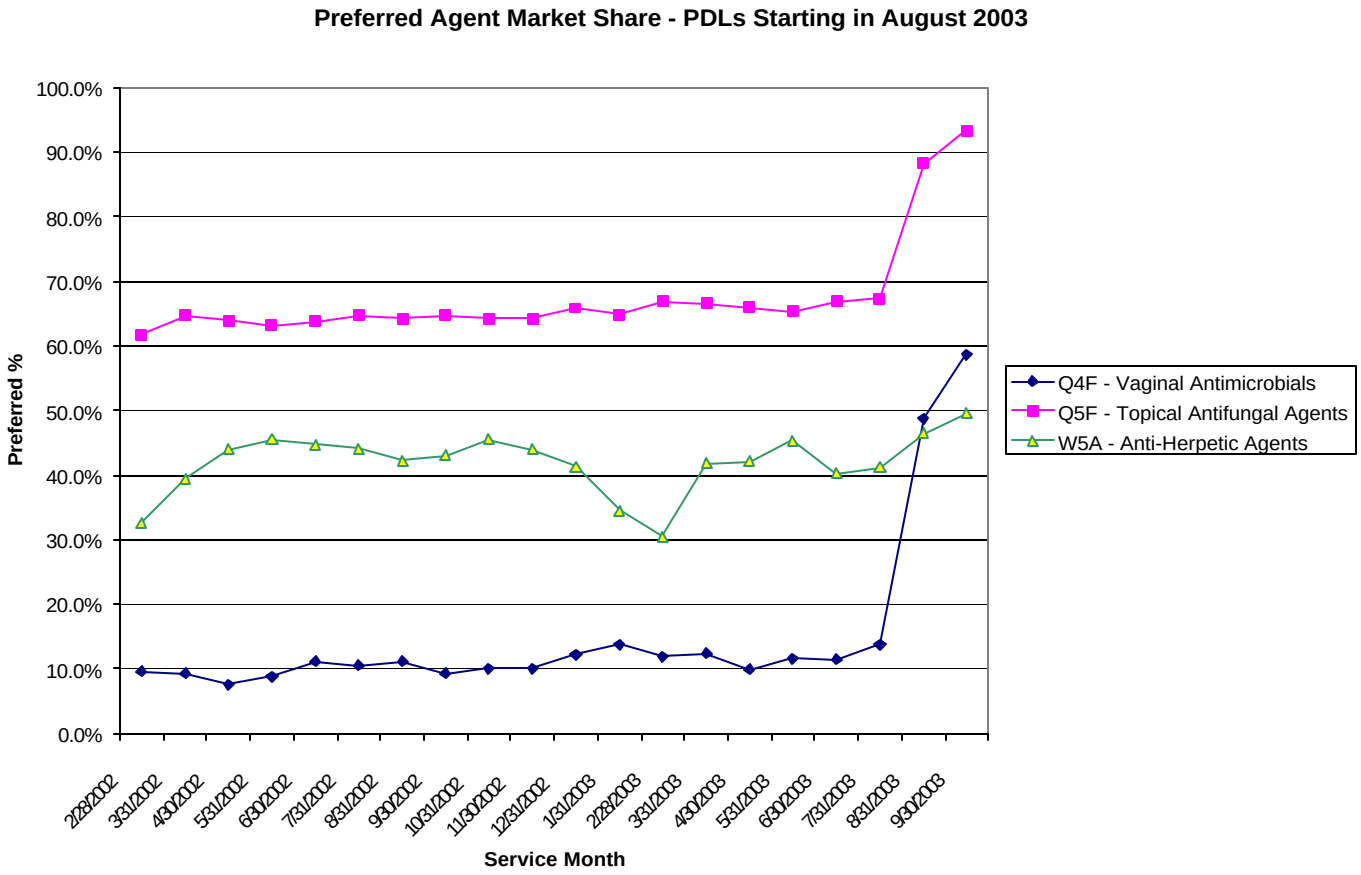

Preferred Agent Market Share - PDLs Starting in Jan 2003
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Preferred %
2/28/2002
3/31/2002
4/30/2002
5/31/2002
6/30/2002
7/31/2002
8/31/2002
9/30/2002
10/31/2002
11/30/2002
12/31/2002
1/31/2003
2/28/2003
3/31/2003
4/30/2003
5/31/2003
6/30/2003
7/31/2003
8/31/2003
9/30/2003
Service Month
A4F - Angiotensin Receptor Blockers
W1D - Macrolides
W1W/X/Y - Cephalosporins
W3B - Antifungals

Preferred Agent Market Share - PDLs Starting in Feb 2003




Preferred Agent Market Share - PDLs Starting in May 2003
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Preferred %
2/28/2002
3/31/2002
4/30/2002
5/31/2002
6/30/2002
7/31/2002
8/31/2002
9/30/2002
10/31/2002
11/30/2002
12/31/2002
1/31/2003
2/28/2003
3/31/2003
4/30/2003
5/31/2003
6/30/2003
7/31/2003
8/31/2003
9/30/2003
Service Month
C4K - Antidiabetic Agents
D7L - Bile Acid Sequestrants
H3A - Brand Name Narcotics
H6H - Skeletal Muscle Relaxants
M4E - Fibric Acids
R1A - Urinary Tract Antispasmodic/Anti Incontinence Agents


Preferred Agent Market Share - PDLs Starting in July 2003
Preferred %
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
2/28/2002
3/31/2002
4/30/2002
5/31/2002
6/30/2002
7/31/2002
8/31/2002
9/30/2002
10/31/2002
11/30/2002
12/31/2002
1/31/2003
2/28/2003
3/31/2003
4/30/2003
5/31/2003
6/30/2003
7/31/2003
8/31/2003
9/30/2003
Service Month
J3A - Smoking Cessation
L9B - topical Vitamin A Derivitives
N1C - Leukocyte Stimulants
Q6G - Miotics/Other intraocular Pressure Reducers
Q6I - Eye Antibiotic/Corticosteroid Combos
Q6R - Eye Antihistamines
Q6U - Ophthalmic Mast Cell Stabilizers
Q6W - Ophthalmic Antibiotics
Q8F/W - Otic Antibiotics


Preferred Agent Market Share - PDLs Starting in August 2003
Preferred %
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2/28/2002
3/31/2002
4/30/2002
5/31/2002
6/30/2002
7/31/2002
8/31/2002
9/30/2002
10/31/2002
11/30/2002
12/31/2002
1/31/2003
2/28/2003
3/31/2003
4/30/2003
5/31/2003
6/30/2003
7/31/2003
8/31/2003
9/30/2003
Service Month
Q4F - Vaginal Antimicrobials
Q5F - Topical Antifungal Agents
W5A - Anti-Herpetic Agents